

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 is retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-61

1
M

07062

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07053

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY in 1b <u>49 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>13316 Andrew Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>M.</u> Last <u>Acorn</u>		4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sep. 2, 1899</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George West Acorn</u>		14. MOTHER'S MAIDEN NAME <u>Ella Jane Clough</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>YES</u>	
17. INFORMANT <u>Mrs. Dorothy D. Acorn</u>		Address <u>5608 Western Ave. Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis & congestive failure</u> DUE TO (c) <u>Immediate</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1959</u> to <u>May 26, 1966</u> that (I) (we) last saw the deceased alive on <u>May 16, 1966</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>A. J. Thibadeau</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>5/28/66</u>
22c. PHYSICIAN'S NAME (Type) <u>A. J. Thibadeau</u>		22d. ADDRESS <u>10111 Colesville, Rd., S. S., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 1, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		25. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>JUN 3 1966</u>		25c. DATE <u>JUN 3 1966</u>	

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JUN 2 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1 (M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07063

CERTIFICATE OF DEATH

07054

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG d. STREET ADDRESS RT.#1 Box 129 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HATTIE Middle ISABELLA Last ADDISON			4. DATE OF DEATH Month MAY Day 11 Year 19 66				
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 21, 1896	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			
13. FATHER'S NAME HOWARD PRATHER			14. MOTHER'S MAIDEN NAME ROSIE LANCASTER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. ---		17. INFORMANT MEDICAL RECORDS, Address OLNEY, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ischemia, Brainstem DUE TO (b) Thrombosis, Basilar Artery DUE TO (c) Atherosclerosis, B.A. + general, Severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days Years.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from May 8 , 19 66 , to May 11 , 19 66 , that (I) (we) last saw the deceased alive on May 11 , 19 66 , and that death occurred at 5 M, from cause and on the date stated above.							
22a. SIGNATURE Frederick Mooman			22b. DATE SIGNED 5-12-66	22c. PHYSICIAN'S NAME (Type)			
23a. BURIAL (CREMATION, RITUAL) (Specify)			23b. DATE THEREOF 5/14/66	23c. NAME OF CEMETERY OR CREMATORY Brooke Grove	23d. LOCATION (City or Town) (County) (State) Laytonsville Montg, Md		
24. FUNERAL DIRECTOR Robert L. Snowden			25. BY REGISTRAR MAY 18 1966				

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DATE: 10/10/00

TO: Mr. J. Edgar Hoover

FROM: Mr. J. Edgar Hoover

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 10/10/00

TO: Mr. J. Edgar Hoover

FROM: Mr. J. Edgar Hoover

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 10/10/00

TO: Mr. J. Edgar Hoover

FROM: Mr. J. Edgar Hoover

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 10/10/00

TO: Mr. J. Edgar Hoover

FROM: Mr. J. Edgar Hoover

07064

CERTIFICATE OF DEATH

07053

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookville Brookville 15-1 d. STREET ADDRESS Box 147 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last David Henry Alsop				4. DATE OF DEATH Month Day Year May 24 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/1/92	
9. AGE (In years last birthday) yrs. 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plumber & heating contractor.		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thaddeus Alsop				14. MOTHER'S MAIDEN NAME Catherine Frank			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes				16. SOCIAL SECURITY NO. None		17. INFORMANT Wm. J. Alsop (brother) Address District Hts. Md. Medical Records Olney, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apoplexia, hemorrhagica 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) with complete left hemiplegia DUE TO (c) Hypertensive cardiac vascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Diabetes mellitus						INTERVAL BETWEEN ONSET AND DEATH 24 hrs 10 yrs	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 23, 1966 , to May 24, 1966 , that (I) (we) last saw the deceased alive on May 24, 1966 , and that death occurred at 10:05 AM , from causes on and on the date stated above.							
22a. SIGNATURE A. D. Bonifant				22b. DATE SIGNED 5/24/1966		22c. PHYSICIAN'S NAME (Type) A.D. Bonifant, M.D.	
22d. ADDRESS Medical Center, Sandy Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 29 May 1966		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Warner E. Humphrey				25. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

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2052

2705

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
07065 07056													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>1 mon / 5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp. of Silver Spring</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9424 Curran Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Clarence C. Andrews</u>			4. DATE OF DEATH <u>May 2 1966</u>			5. SEX <u>male</u>			6. COLOR OR RACE <u>White</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>11/5/13</u>			9. AGE (In years last birthday) <u>53</u> yrs.			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electric Technician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Communications Satellite</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Rt.</u>					
13. FATHER'S NAME <u>Charles E. Andrews</u>						14. MOTHER'S MAIDEN NAME <u>Anna Kersler</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>171 05 9362</u>				17. INFORMANT <u>C. Katherine Andrews</u> Address <u>9424 Curran Road Silver Spring, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute hemorrhagic pancreatitis</u> 576X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Retroperitoneal hemorrhage</u> DUE TO (c) <u>Subdiaphragmatic abscess</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>28 MAR, 1966</u> , to <u>2 MAY, 1966</u> , that (I) <u>two</u> last saw the deceased alive on <u>3 MAY 1966</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Richard Compton</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>3 MAY 66</u>				
22c. PHYSICIAN'S NAME (Type) <u>J. RICHARD COMPTON</u>						22d. ADDRESS <u>612 MAIN ST., LAUREL, MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 6, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Memorial Park</u>				23d. LOCATION (City, town or county) (State) <u>Paramus, New Jersey</u>					
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>44 Georgia Avenue Silver Spring, Md.</u>						25a. REC'D BY REGISTRAR <u>May 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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1 (M)
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07066		07057	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Virginia</i> b. COUNTY <i>Orange</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arlington</i>	
c. LENGTH OF STAY IN 1b <i>DOA</i>		d. STREET ADDRESS <i>3701 So. 5th St. #504</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ray</i> Middle <i>Carson</i> Last <i>Bailey</i>		4. DATE OF DEATH Month <i>5</i> Day <i>30</i> Year <i>1966</i>	
5. SEX <i>m</i>	6. COLOR OR RACE <i>claw</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/20/19</i>
9. AGE (In years last birthday) <i>46</i> yrs.		10. IF UNDER 1 YEAR Months <i>4</i> Days <i>19</i> Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unk. Auditor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Interstate</i>	
11. BIRTHPLACE (State or foreign country) <i>Onaway, Mich.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown Earl Bailey</i>		14. MOTHER'S MAIDEN NAME <i>Mrs. A. J. Torrance</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes Marine</i>		16. SOCIAL SECURITY NO. <i>566-12-6996</i>	
17. INFORMANT <i>Mrs. Lt. Col. Mildred C. Bailey</i>		18. ADDRESS <i>3701 S. 5th St. Arlington, Va.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Injuries multiple, severe</i> 8234 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Automobile accident</i> DUE TO (c) <i>8234</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Car went out of control on highway 495.</i>	
20c. TIME OF INJURY Month, Day, Year <i>8:35 p.m. 5/30 1966</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>	20f. (City or town) (County) (State) <i>Bethesda Mont. Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John E. Ball</i>		22. DATE SIGNED <i>5/31/66</i>	
EXAMINER'S NAME (Type) <i>John E. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>6/2/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem, Arlington, Virginia</i>	23d. LOCATION (City, town or county) (State) <i>Arlington, Virginia</i>
24. FUNERAL DIRECTOR <i>John C. Thomas</i>		25a. REC'D BY REGISTRAR <i>JUN 3 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS <i>Murphy Funeral Home 3524 Columbia Pike, Arl. Va.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

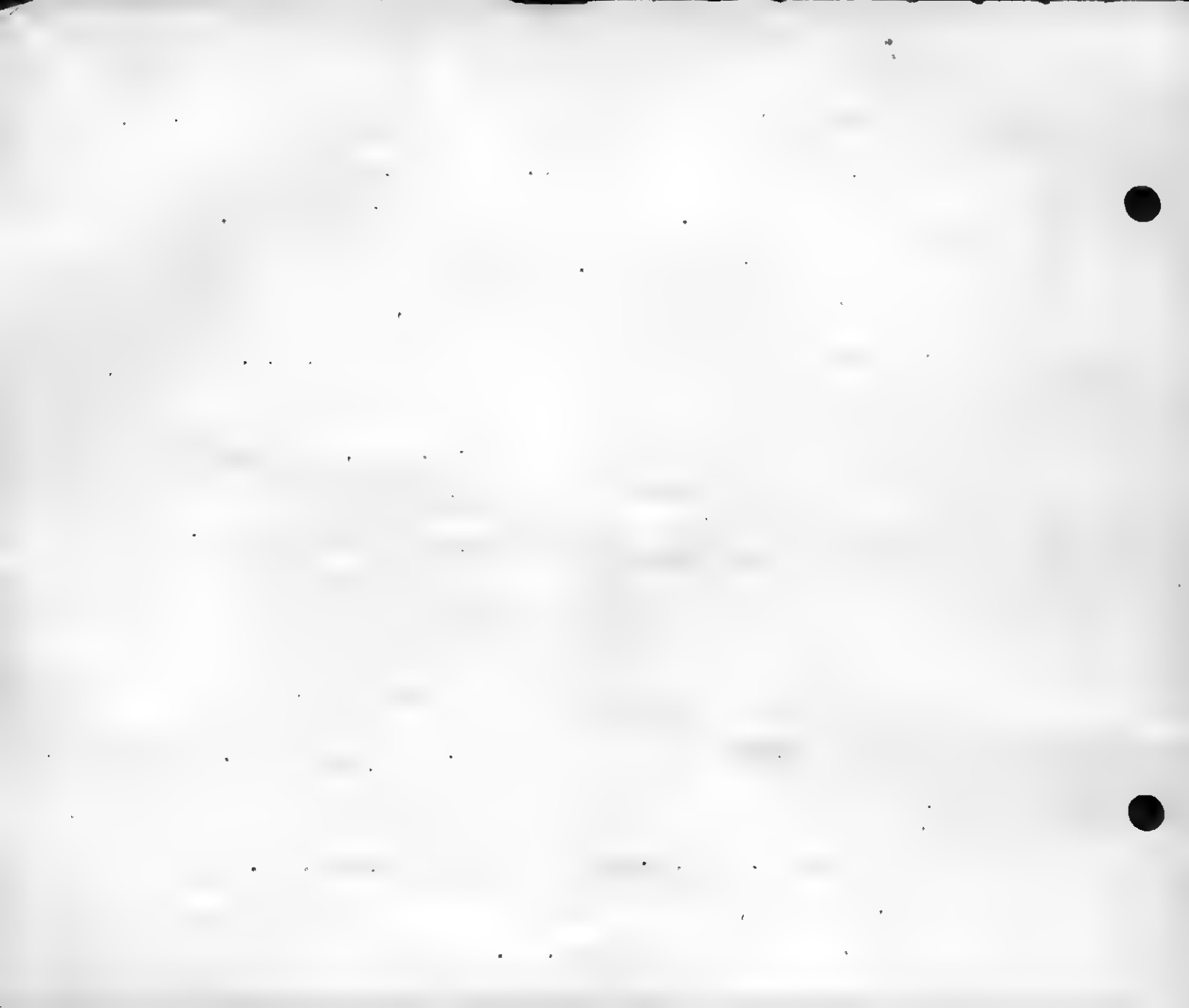
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C7067

07058

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Damascus c. LENGTH OF STAY IN ID 14 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 26613 Ridge Rd.			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Damascus d. STREET ADDRESS 26613 Ridge Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Nettie Middle I. Last Balderson			4. DATE OF DEATH Month May Day 27 Year 1966		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH June 10, 1879		9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Parishville, N.Y.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Emory Hall		
14. MOTHER'S MAIDEN NAME Olive Champine			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		
16. SOCIAL SECURITY NO. None			17. INFORMANT Jerry L. Cook, Item 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4221 DUE TO (b) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 1 week 10 yrs. or less
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) James P. Kerr M.D. attended the deceased from 4/15 1966 to 5/27 1966 , that (I) last saw the deceased alive on 5/27 1966 , and that death occurred at 8:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE James P. Kerr M.D.		22b. DATE SIGNED 5/28/66		22c. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.	
22d. ADDRESS Damascus, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF June 1, 1966		23c. NAME OF CEMETERY OR CREMATORY Oakwood		23d. LOCATION (City, town or county) (State) Theresa, New York	
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR JUN 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																								
C7068					CERTIFICATE OF DEATH					C7059														
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hosp.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1656 Park Road, N.W.</u> d. STREET ADDRESS <u>Washington, D.C.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First <u>Marguerite M.</u> Middle <u>BANNON</u> Last <u>BANNON</u>					4. DATE OF DEATH Month <u>MAY</u> Day <u>8</u> Year <u>1966</u>																			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-23-95</u>		9. AGE (in years last birthday) <u>70 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KING OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <u>Canada</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>									
13. FATHER'S NAME <u>Robert Williamson</u>					14. MOTHER'S MAIDEN NAME <u>Margaret Regan</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>(If yes give war or dates of service)</u>					17. INFORMANT <u>daughter</u> Address <u>Mrs. E. J. Francella 11807 Ingwood Rd SSMD</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> (c) <u>Generalized Arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>6 days</u> <u>6 days</u>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>5/2/66</u> to <u>5/8/66</u> , that (I) (we) last saw the deceased alive on <u>5/8/66</u> , and that death occurred at <u>9:50 PM</u> from the causes and on the date stated above.																								
22a. SIGNATURE <u>John J. Curry</u>										22b. DATE SIGNED <u>5/8/66</u>														
22c. PHYSICIAN'S NAME (Type) <u>JOHN J. CURRY</u>										22d. ADDRESS <u>10620 Georgia Ave NW</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					23b. DATE THEREOF <u>12 MAY 1966</u>					23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>					23d. LOCATION (city, town or county) (State) <u>SILVER SPRING MD.</u>									
24. FUNERAL DIRECTOR <u>KINALDI FUNERAL HOME</u>										25a. REC'D BY REGISTRAR <u>Charles Judge</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									
DATE <u>MAY 10 1966</u>																								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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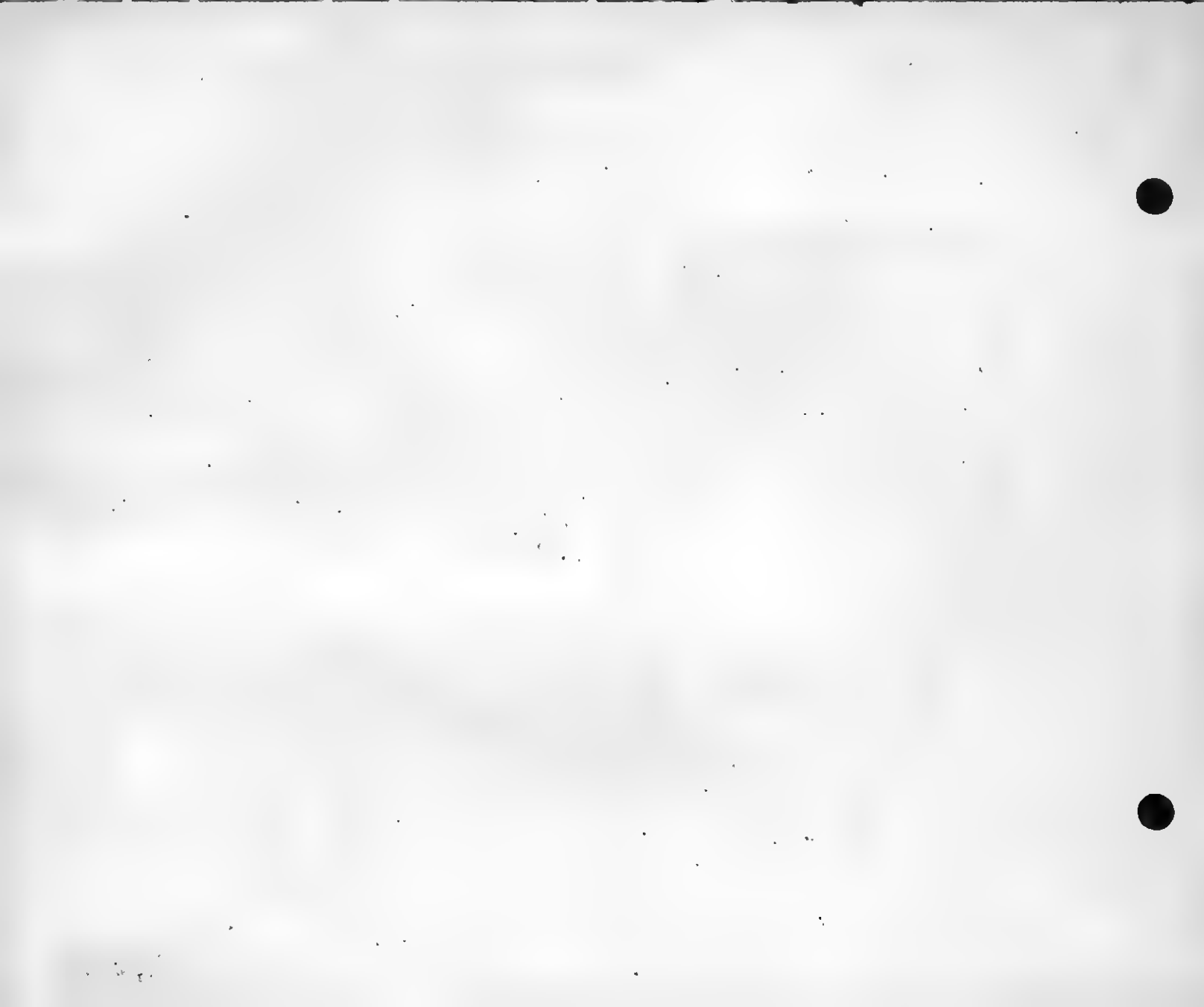
VR A15 (4)
ZDM 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
67063
CERTIFICATE OF DEATH WILLIAM F. BARNUM

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN b <u>3 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONT</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> d. STREET ADDRESS <u>22 GRANT AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>WILLIAM FREDERICK BARNUM</u>		4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>1966</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-9-84</u>		9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>US AIR FORCE (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>NY</u>				12. CITIZEN OF WHAT COUNTRY? <u>AMER.</u>			
13. FATHER'S NAME <u>WILLIAM BARNUM</u>				14. MOTHER'S MAIDEN NAME <u>MARY SLATER</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>1946-1948</u>				16. SOCIAL SECURITY NO. <u>26-12</u>			
17. INFORMANT <u>Charles</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Myocardial Infarction</u> DUE TO (b) <u>Semile Arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>67 hrs</u> <u>10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>1946</u> , 19 <u>50</u> to <u>5/1/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/30/66</u> , 19 <u>66</u> , and that death occurred at <u>10:4</u> M, from the causes and on the date stated above.															
22a. SIGNATURE <u>H.B. Queen</u>				22b. DATE SIGNED <u>5/1/66</u>											
22c. PHYSICIAN'S NAME (Type) <u>H.B. QUEEN</u>				22d. ADDRESS <u>7112 Willow Ave TAKOMA PARK, MD</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>May 4, 1966</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>				23d. LOCATION (City, town or county) (State) <u>Colmar Manor MD</u>											
24. FUNERAL DIRECTOR <u>J. Arthur Walters</u>				25. REC'D BY REGISTRAR <u>MAY 4 1966</u>											
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>															

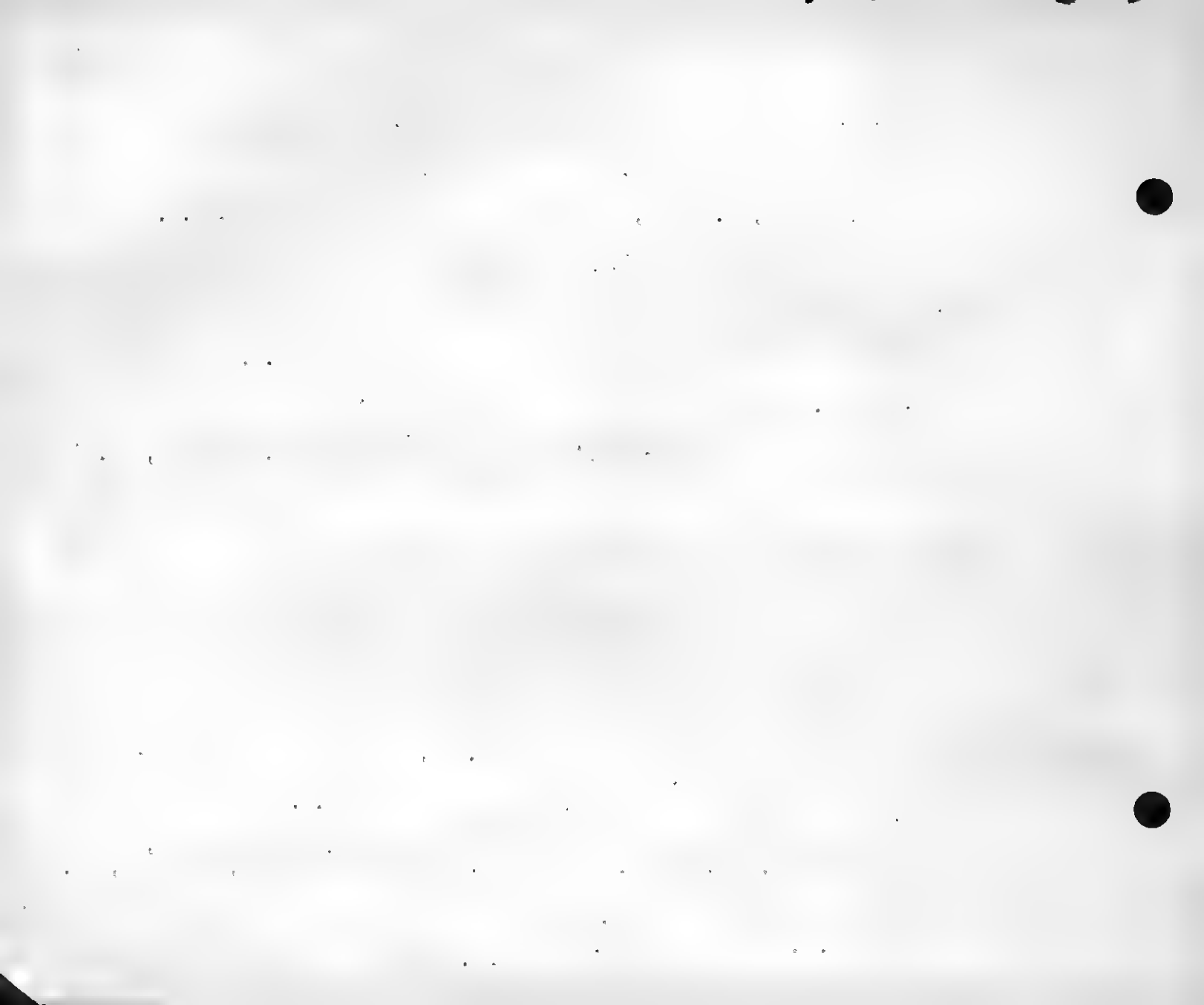
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07061											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 821 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1729 Lamont Street, N.W. d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Lee Middle Kirby Last Barrett			4. DATE OF DEATH Month May Day 28 Year 19 66								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 May 1926		9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gambler				10b. KIND OF BUSINESS OR INDUSTRY Gambling		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel M. Barrett					14. MOTHER'S MAIDEN NAME Hilda Kirby						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (if yes give war or dates of service) No					16. SOCIAL SECURITY NO. Unobtainable					17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypoventilation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Amyotrophic Lateral Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 1 hour 4 years	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that 20 (this hospital) attended the deceased from Feb. 27, 1964 , to May 28, 1966 , that 21 (we) last saw the deceased alive on May 28, 1966 , and that death occurred at 9:00 A.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Jon D. Dorman</i> 22c. PHYSICIAN'S NAME (Type) Jon D. Dorman, MD.								22b. DATE SIGNED P.M. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation			23b. DATE THEREOF 5/31/66		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory			23d. LOCATION (City, town or county) (State) Prince Georges County Md.			
24. FUNERAL DIRECTOR The S.H. Hines Company Washington, D.C.						25a. REC'D BY REGISTRAR JUN 2 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
07062									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 329 Maryland Ave. N. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First MATTIE Middle BARTLE Last BARTLE					4. DATE OF DEATH Month MAY Day 19 Year 1966				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ?		9. AGE (in years last birthday) 96 yrs. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles P. Jones					14. MOTHER'S MAIDEN NAME ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Wm. J. Bartle 329 Md. Ave. D. C. Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 14X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) ESSENTIAL HYPERTENSION DUE TO (c) GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) SENILITY								INTERVAL BETWEEN ONSET AND DEATH —	
								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
								20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from JUNE 19, 1961 to MAY 19, 1966 , that (I) (we) last saw the deceased alive on MAY 19, 1966 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Henry M. Lowden					22b. DATE SIGNED 5/19/66		22c. PHYSICIAN'S NAME (Type) Henry M. Lowden		
22d. ADDRESS 5306 Morning Dr. Chevy Chase 1, D.C.					22e. M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF 5/19/66		23c. NAME OF CEMETERY OR CREMATORY Lee's		23d. LOCATION (City, town or county) (State) Washington, D.C.		
24. FUNERAL DIRECTOR Lee Funeral Home					25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		
26. ADDRESS Washington, D.C.									
MAY 23 1966									

C7072

CERTIFICATE OF DEATH

C7063

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN 1b <i>Wash. D.C.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>Wash. D.C.</i>	
3 NAME OF DECEASED (Type or print) <i>Clara Ann Belkov</i>		4 DATE OF DEATH Month <i>5</i> Day <i>26</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-15-95</i>
9. AGE (In years last birthday) <i>71</i> yrs		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>19</i> Hours <i>66</i> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <i>Baltimore, Md</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13 FATHER'S NAME <i>Morris Tishler</i>		14. MOTHER'S MAIDEN NAME <i>Lena -</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16 SOCIAL SECURITY NO <i>225-07-5284</i>	
17 INFORMANT <i>Wife, Mr Sol Belkov</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute myocardial failure</i> <i>4200</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>-</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 22, 1963</i> , to <i>May 26, 1966</i> , that (I) (we) last saw the deceased alive on <i>April 18, 1966</i> , and that death occurred at <i>1:00 A.M.</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Benjamin Isaacson, M.D.</i>		22b. DATE SIGNED <i>5/26/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>BENJAMIN ISAACSON M.D.</i>		22d. ADDRESS <i>7733 Alaska Ave N.W. Wash. D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>5-29-66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>WATHAM PARK</i>		23d. LOCATION (City or Town) (County) (State) <i>FAIRFAX COUNTY VA</i>	
24 FUNERAL DIRECTOR <i>GOLDERS FUNERAL HOME 4712 9th St NW</i>		25a. REC'D BY REGISTRAR <i>JUN 1 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>J Charles J...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 cleared by Med Examiner for signature by family Dr.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

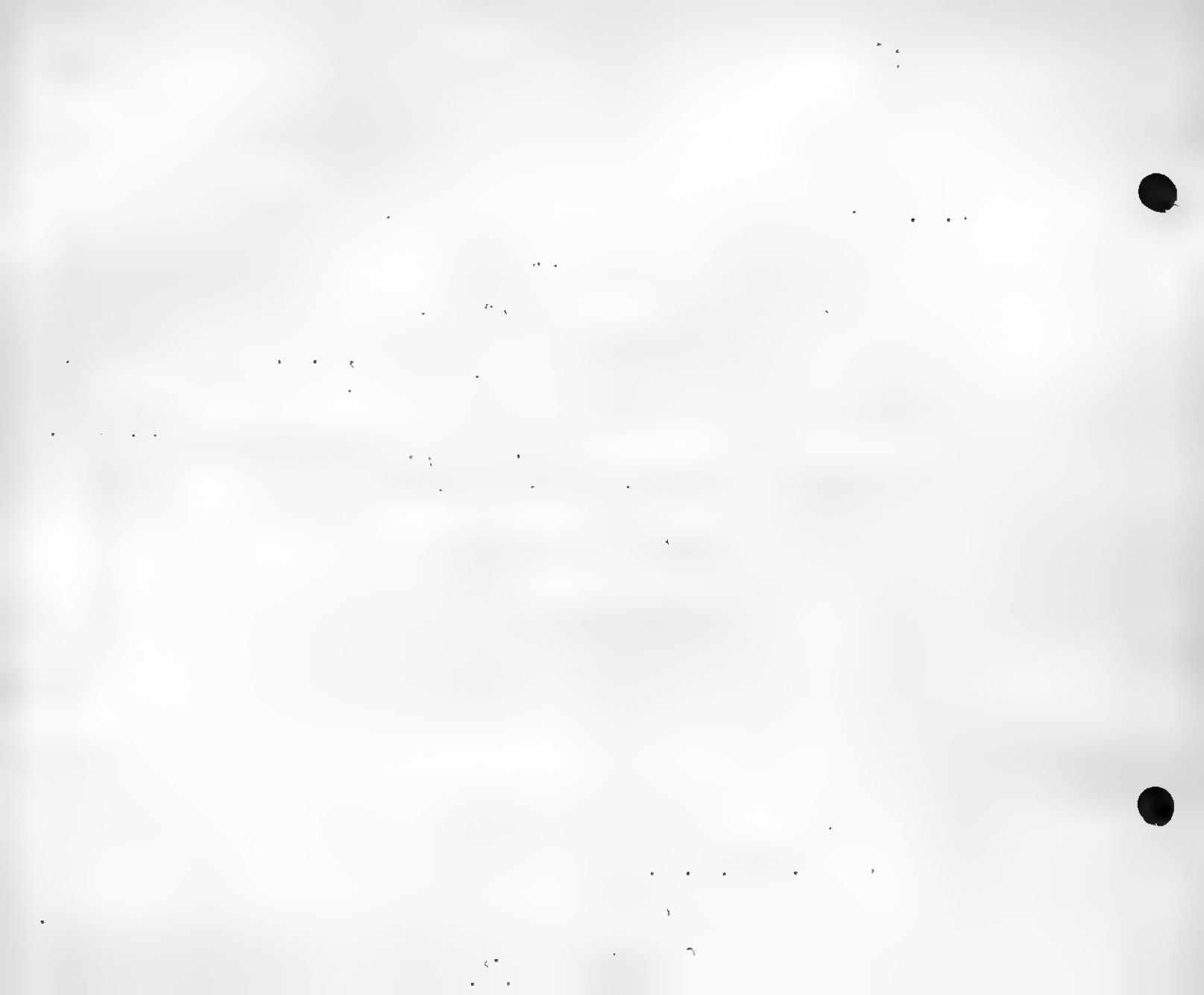
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Bethesda	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 4949 Battery Lane	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise Middle Marie Last BERNARD		4. DATE OF DEATH Month May Day 27 Year 1966	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1892
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 73 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker		10b. KIND OF BUSINESS OR INDUSTRY Fabric manufacturing	
11. BIRTHPLACE (State or foreign country) Providence, R. I.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ernest Bizat		14. MOTHER'S MAIDEN NAME Erma Larmee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Frank L. Arnold, 4949 Battery Lane		Address Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency acute 4201 DUE TO (b) Coronary arteriosclerosis DUE TO (c) Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH sudden years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		22. DATE SIGNED 27 May 1966	
EXAMINER'S NAME (Type) John G. Ball, M. D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/31/66	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City, town or county) (State) Silver Spring Md.	
24. FUNERAL DIRECTOR Chevy Chase Funeral Home		25a. REC'D BY REGISTRAR JUN 3 1966	
ADDRESS 5103 Wisconsin Ave., NW Washington, D. C.		25b. REGISTRAR'S SIGNATURE Charles Judge	



CERTIFICATE OF DEATH

07074

07065

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince Georges County c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		e. STREET ADDRESS Building 4, Apt. 301		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jennie Bernstein (no middle name)		4. DATE OF DEATH 5/23/1966		Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/7/1871		9. AGE (In years last birthday) 94 yts
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-factory worker		10b. KIND OF BUSINESS OR INDUSTRY Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (last name changed to Bernstein) Abraham Boraso		14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO none		17. INFORMANT Ethel Krawitz, see 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 151X <i>Concussion of Skull</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malignant					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Oct. , 1964, to May , 1966, that (I) (we) last saw the deceased alive on May 22 , 1966, and that death occurred at 12:00 M., from causes and on the date stated above.					
22a. SIGNATURE <i>Irwin H. Ardham</i>		22b. DATE SIGNED 5-23-66		22c. PHYSICIAN'S NAME (Type) IRWIN H. ARDAM	
22d. ADDRESS 1712 - F - St. N.W., WASH. C. D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-27-66	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	23d. LOCATION (City or Town) (County) (State) Maspeth, L.I., N.Y.		
24. FUNERAL DIRECTOR <i>Shelberg Funeral Home</i>		25a. REC'D BY REGISTRAR MAY 31 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



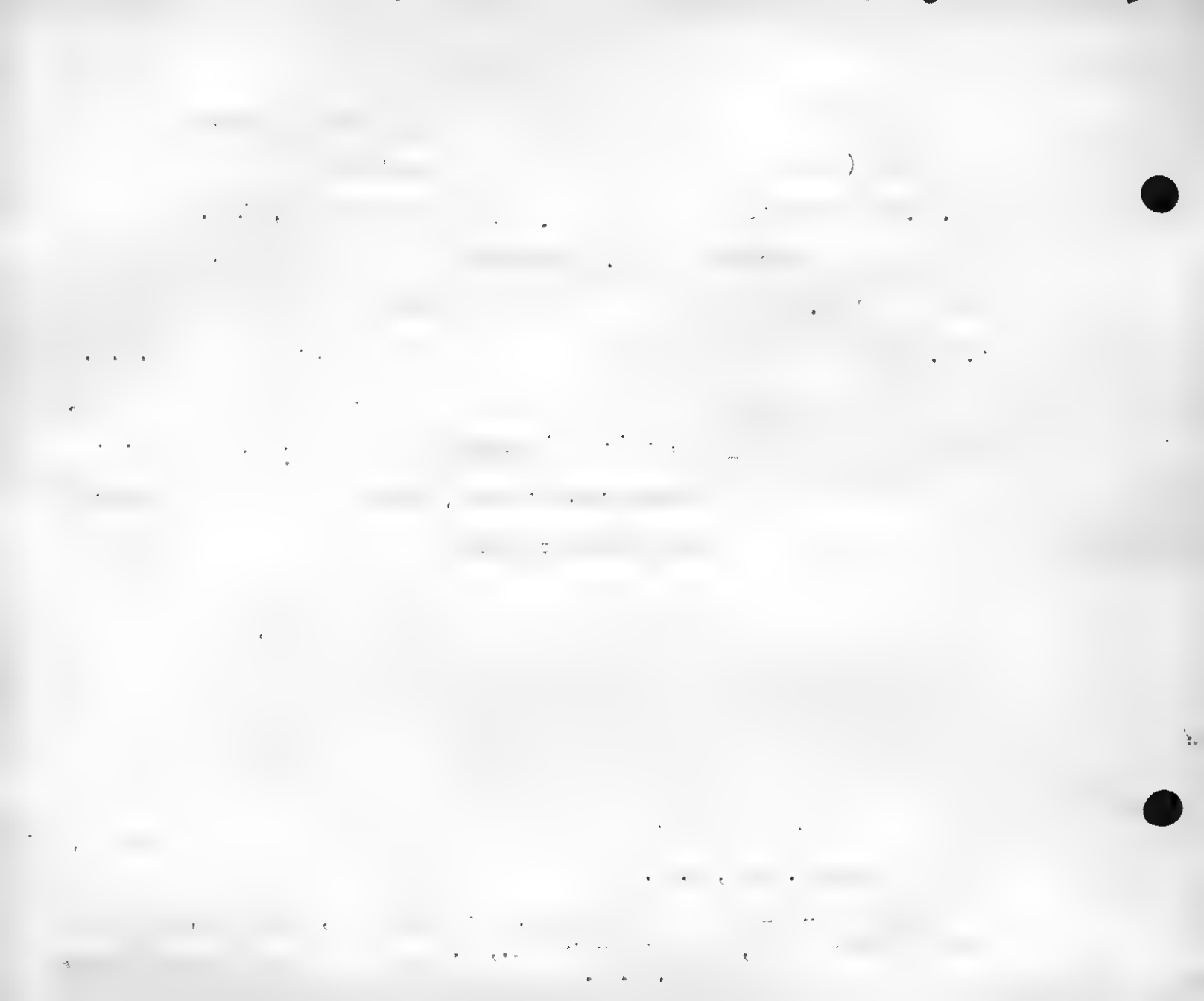
FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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<div>Item 18b Film G378 6/20/66</div> <div>Item 1d Film G377 6/15/66</div> <div>Item 18b Film G378 6/20/66</div> <div>Item 1d Film G377 6/15/66</div>														
<div>Item 18b Film G378 6/20/66</div> <div>Item 1d Film G377 6/15/66</div> <div>Item 18b Film G378 6/20/66</div> <div>Item 1d Film G377 6/15/66</div>														
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY District of Columbia c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 5032 Lowell Street, N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Harold W. Blakeley			4. DATE OF DEATH Month May Day 10 Year 1966			5. SEX Male			6. COLOR OR RACE Cauc.			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH 12-29-1893			9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR: Months 72 Days 0 Hours 0 Min. 0			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Army			10b. KIND OF BUSINESS OR INDUSTRY Retired			11. BIRTHPLACE (State or foreign country) Massachusetts		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John Blakeley			14. MOTHER'S MAIDEN NAME Carrie Skinner			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) Retired 4-30-46			16. SOCIAL SECURITY NO. 579-48-0763		
17. INFORMANT See Item No. 2.			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency, acute 4201 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (b) Hypertensive Cardiovascular disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH sudden years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						
20f. (City or town)				(County)				(State)						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED May 10, 1966						
EXAMINER'S NAME (Type) John G. Ball, M. D.				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
Address (Street, city, town, or county)														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-12-1966				23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Virginia						
23d. LOCATION (City, town or county)				(State)				24. FUNERAL DIRECTOR Joseph Gawler & Sons, 5130 Wisconsin Ave., N.W.						
25a. REC'D BY REGISTRAR MAY 13 1966				25b. REGISTRAR'S SIGNATURE Charles Judge				25c. DATE						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07067											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>503 Woodburn Rd.</u>					d. STREET ADDRESS <u>503 Woodburn Road</u>						
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Mae</u> Last <u>Blankenship</u>					4. DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>1966</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 16, 1903</u>		9. AGE (in years last birthday) <u>62</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Joseph Wolfe</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Cannoy</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO.		17. INFORMANT <u>Henry B. Blankenship same item #2 - Husband</u>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Abscess, rt hip</u> DUE TO (c) <u>Reticulum Cell Sarcoma of Bone</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>2-4 days</u> <u>2 yrs</u> <u>3 1/2 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Jun</u> , 1963, to <u>5/3</u> , 1966, that (I) (we) last saw the deceased alive on <u>5/2</u> , 1966, and that death occurred at <u>2:50 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>G. Lennard Gold</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/3/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold</u>					22d. ADDRESS <u>8641 Colesville Road, Silver Spring</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>May 6, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>				
24. FUNERAL DIRECTOR <u>Tyson Wheeler F.H.</u>					ADDRESS <u>1331 Rockville Pike Rockville, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAY 5 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
C7077					C7068										
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)										
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY								
Montgomery		Silver Spring			Maryland		Montgomery								
		c. LENGTH OF STAY IN ID			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)										
		19 days			Bethesda										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?							
Holy Cross Hospital					10415 Montrose Avenue			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First		Middle	Last	4. DATE OF DEATH		Month	Day	Year					
		Frances		M.	Bloodgood			May	31	1966					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS.				
F		W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		July 6, 1878		87 yrs.		Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Housewife				-		Iowa		U.S.A.							
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME										
Frank Mason					- - - Montague										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT			Address					
No					None		Frances Lusby			Bethesda, Md.					
					10415 Montrose Ave.										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										years					
4:1															
DUE TO															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO															
(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED?					
Coarctation Heart Failure; Atherosclerosis										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year										20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m. 19										While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from 4/-, 1966, to 5/30, 1966, that (I) (we) last saw the deceased alive on 5/30, 1966, and that death occurred at 2:30 A.M. from the causes and on the date stated above.															
22a. SIGNATURE										22b. DATE SIGNED					
Irvin Ardum										5-31-66					
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS					
Irvin Ardum										1712 - I - St. L. W. Wash. Bldg.					
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial										6-2-1966		Ft. Lincoln Cemetery		Prince Georges Co., Md.	
24. FUNERAL DIRECTOR										ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Joseph Sauter & Sons												JUN 3 1966		Charles Judge	



07078

CERTIFICATE OF DEATH

07083

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>9 days</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Bethesda) Bethesda</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d STREET ADDRESS <u>5511 JOHNSON AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Marie K. Bonny Castle</u>				4. DATE OF DEATH <u>May 18 1966</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/2/79</u>	9 AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Mins.
10a USAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b KIND OF BUSINESS OR INDUSTRY <u>—</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Lagan P Kennedy</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Lethgow</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT (Daughter) <u>Mrs. Robert H. Beall Bethesda, Md</u>			
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Branchopneumonia</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> DUE TO (d) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pathologic fracture (R) hip; Metastatic Carcinoma</u>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>5-9</u> , 1966, to <u>5-18</u> , 1966, that (I) (we) lost saw the deceased alive on <u>5-17</u> , 1966, and that death occurred at <u>11:00</u> A.M. from causes and on the date stated above.							
22a SIGNATURE <u>Donald L. Bucy</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>5-18-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DONALD L. BUCY</u>				22d ADDRESS <u>809 Veirs Mill Rd MONT. Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-23-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington Va.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				25a. REC'D BY REGISTRAR <u>MAY 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician and completely filled by the funeral director. After this certificate has been signed by the attending physician, the funeral director, and the physician, the certificate should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

BP

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C7073

27069

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> c. LENGTH OF STAY IN 1b <u>18 mos</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wheaton Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D. C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> d. STREET ADDRESS <u>3500 14th Street N. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET C. Bowman</u> f. SEX <u>F</u> g. COLOR OR RACE <u>W</u> h. MARIED <input type="checkbox"/> EVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>MAY 2 1908</u> i. AGE (in years last birthday) <u>98</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.		4. DATE OF DEATH <u>MAY 24 1966</u> j. BIRTHPLACE (County & State, or foreign country) <u>PA. - U.S.</u> k. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
5. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> l. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> m. BIRTHPLACE (County & State, or foreign country) <u>PA. - U.S.</u> n. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		6. FATHER'S NAME <u>Lebius Kunkle</u> o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> p. SOCIAL SECURITY NO <u>577-30-0085B</u> q. INFORMANT <u>Nursing Home Records - same as above</u>	
7. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cholecystitis</u> 15 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart disease (3 yrs)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NO</u> 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NO</u> 20f. (City or town) (County) (State) <u>NO</u>		21. I certify that (I) (this hospital) attended the deceased from <u>May 21, 1966</u> to <u>May 24, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 21, 1966</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Malcolm D. Harrison</u> 22c. PHYSICIAN'S NAME (Type) <u>MALCOLM D. HARRISON</u> 22d. ADDRESS <u>4535 Yuma St NW Wash. DC</u>		22b. DATE SIGNED <u>May 24, 1966</u> 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. REC'D BY REGISTRAR <u>MAY 25 1966</u> 22g. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>5/26/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Prince Georges Co. Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Hyman Co., 2901 14th NW</u> 25a. REC'D BY REGISTRAR <u>MAY 25 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

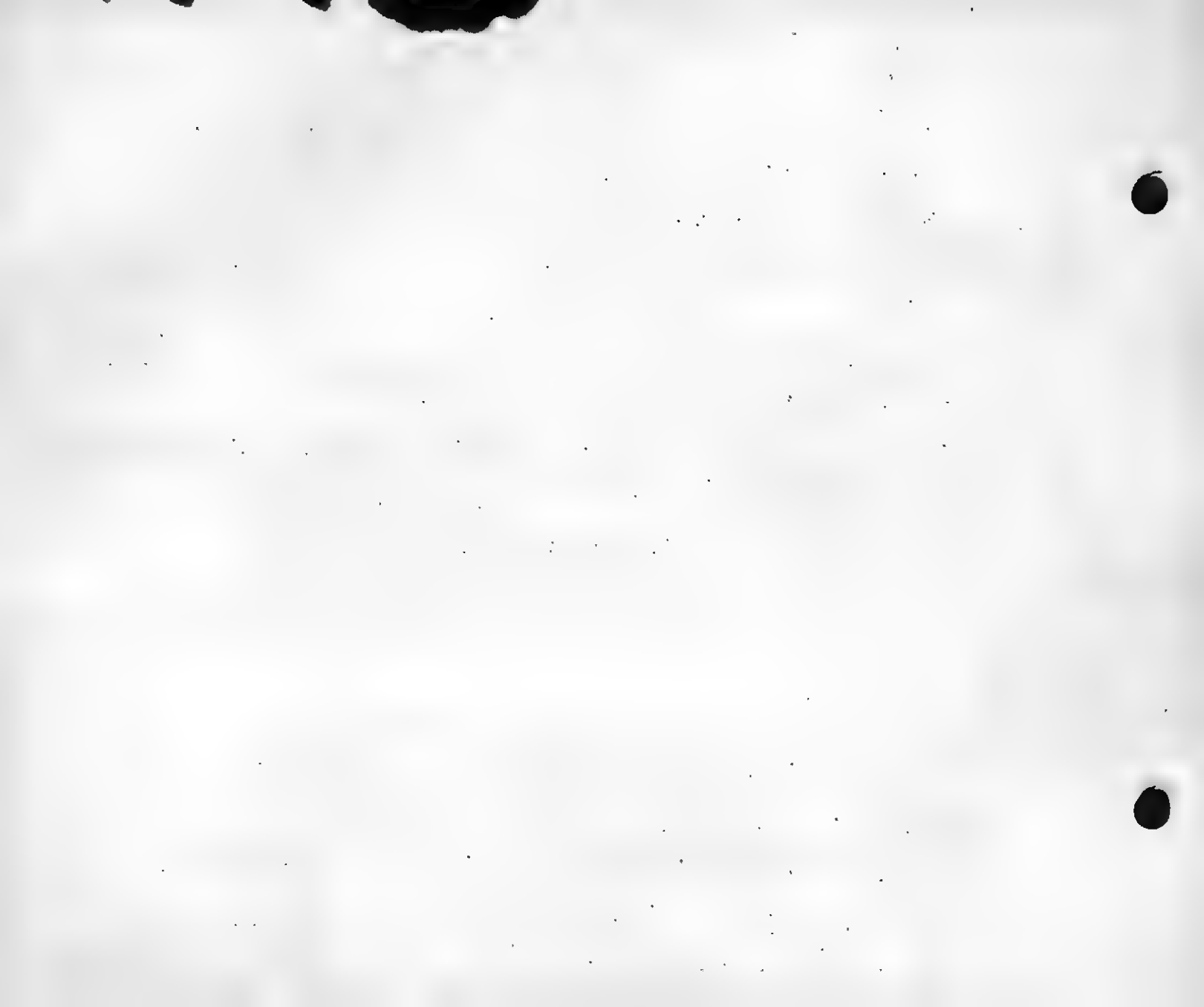
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07080

07070

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM & HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>8912 FAIRVIEW ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>GEORGE (NMN) BRANDT</u>		4. DATE OF DEATH <u>MAY 8 1966</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 1 1882</u>		9. AGE (In years last birthday) <u>83 yrs.</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CABINET MAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Woodward & Lothrop</u>				11. BIRTHPLACE (County & State, or foreign country) <u>GERMANY</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Heinrick Brandt</u>						14. MOTHER'S MAIDEN NAME <u>? Kammer</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-01-5644</u>				17. INFORMANT <u>Walter W. Brandt</u> Address <u>1415 Stateside Dr. Hospital Records Silver Spring, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>4 years</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1958</u> to <u>May 8 1966</u> , that (I) (we) last saw the deceased alive on <u>May 8 1966</u> , and that death occurred at <u>5:25 PM</u> , from the causes and on the date stated above.															
22a. SIGNATURE <u>John N. Andrews</u>												22b. DATE SIGNED <u>5-8-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>												22d. ADDRESS <u>2001 Colesville Rd Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>11 May 1966</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>												25a. REC'D BY REGISTRAR <u>MAY 12 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
C7081					CERTIFICATE OF DEATH					07071	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia b. COUNTY						
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 3 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethesda-Silver Spring Nursing Home					d. STREET ADDRESS 3284 Aberfoyle Pl., N.W.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ETHEL Middle L Last BRANSON					4. DATE OF DEATH Month 5 Day 14 Year 19 66						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 23, 1882		9. AGE (In years last birthday) yrs 83		IF UNDER 1 YEAR Months 7 Days 21 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME ?					14. MOTHER'S MAIDEN NAME ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO Unknown		17. INFORMANT Son Bruce S. Branson, Jr.			Address Same as Item 2.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia, bronchial										INTERVA. BETWEEN ONSET AND DEATH 2 wks years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 4/19 , 19 66 , to 5/14 , 19 66 , that (I) (we) last saw the deceased alive on 5/13 , 19 66 , and that death occurred at 4:50 A.M. from causes and on the date stated above.											
22a. SIGNATURE <i>G. Lennard Gold</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/14/66				
22c. PHYSICIAN'S NAME (Type) G. LENNARD GOLD					22d. ADDRESS 6641 Coleridge Road, Silver Spring						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5-16-66		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			23d. LOCATION (City or Town) (County) (State) Washington, D. C.			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY					ADDRESS Bethesda, Maryland			25a. REC'D BY REGISTRAR MAY 17 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 250 Film 6376 5/16/66 mn

C7082

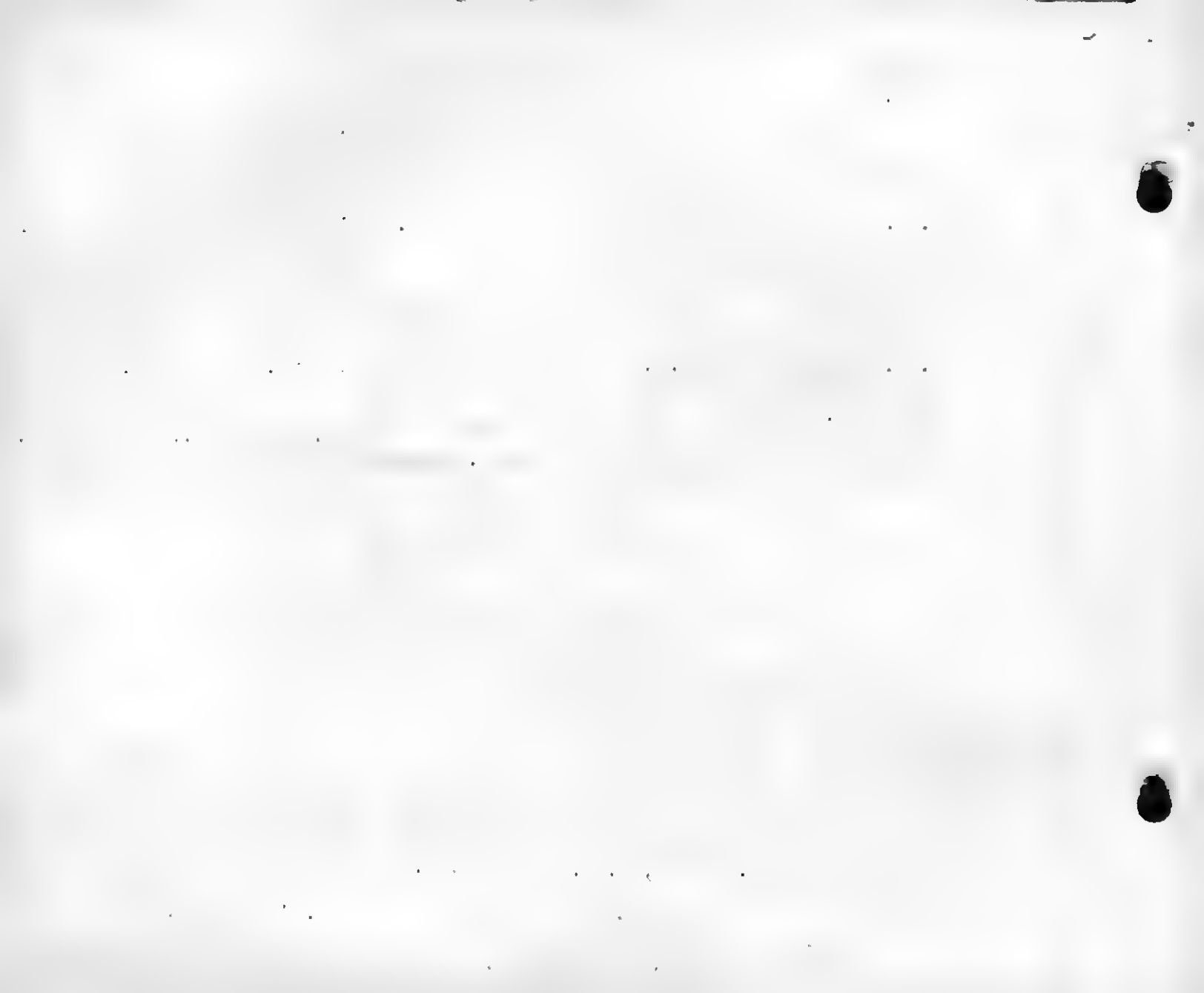
CERTIFICATE OF DEATH

07072

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Penn. b. COUNTY Northumberland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 58 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Atlas			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				a. STREET ADDRESS 222 W. Saylor Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) William James BRANZ				4 DATE OF DEATH Month May Day 7 Year 1966			
5 SEX Male	6 COLOR OR RACE Cauc.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 Mar 1915		9 AGE (In years last birthday) yrs 51	IF UNDER 1 YEAR Months 1 Days 3 IF UNDER 24 HRS Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy (Retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government		11 BIRTHPLACE (County & State, or foreign country) Conersville, Penn.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Modesto J. BRANZ				14 MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16 SOCIAL SECURITY NO 166-14-3083		17 INFORMANT 222 W. Saylor St., Atlas, Penn. Mrs. Catherine BRANZ			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of pancreas with widespread metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Terminal pulmonary embolism DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from 9 March , 19 66 , to 7 May , 1966, that (b) (we) last saw the deceased alive on 7 May , 1966, and that death occurred at 11:45 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Donald K. Roeder</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9 May 1966	
22c. PHYSICIAN'S NAME (Type) Donald K. Roeder, M. D.				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF May 12, 1966		23c NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		23d LOCATION (City or Town) (County) (State) Mt. Carmel, Pennsylvania	
24 FUNERAL DIRECTOR R.A. Pumphrey Funeral Home 7557 Wisconsin Avenue, Bethesda, Md.				25a REC'D BY REGISTRAR DATE MAY 10 1966		25b REGISTRAR'S SIGNATURE <i>John Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



C7083

CERTIFICATE OF DEATH

C7073

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution before admission) a. STATE VIRGINIA b. COUNTY HENRICO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 8 HRS. 36 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HIGHLAND SPRINGS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL				d. STREET ADDRESS 508 DALE ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last BRENT				4. DATE OF DEATH Month 5 Day 24 Year 19 66			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-66		9. AGE (In years last birthday) 0 yrs	IF UNDER 1 YEAR Months 8 Days 36	IF UNDER 24 HRS. Hours 8 Min. 36
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MONTGOMERY COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH MILTON HOFFARTH				14. MOTHER'S MAIDEN NAME REITA SUSAN BRENT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO NONE		17. INFORMANT HOSPITAL RECORDS Address OLNEY, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 7625 IMMEDIATE CAUSE (a) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Bilateral pulmonary steleostosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 24 (1 AM) 19 66 to May 24 (4 PM) 19 66 that (I) (we) last saw the deceased alive on May 24 19 66 , and that death occurred at 9:45 AM , from causes and on the date stated above.							
22a. SIGNATURE James P. Kerr				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/24/66	
22c. PHYSICIAN'S NAME (Type) J. P. KERR, M. D.				22d. ADDRESS DAMASCUS, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-25-66		23c. NAME OF CEMETERY OR CREMATORY Laytons ville		23d. LOCATION (City or Town) (County) (State) Laytons ville, Md.	
24. FUNERAL DIRECTOR Francis H. Barber				ADDRESS Laytons ville, Md.		25a. REC'D BY REGISTRAR MAY 27 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

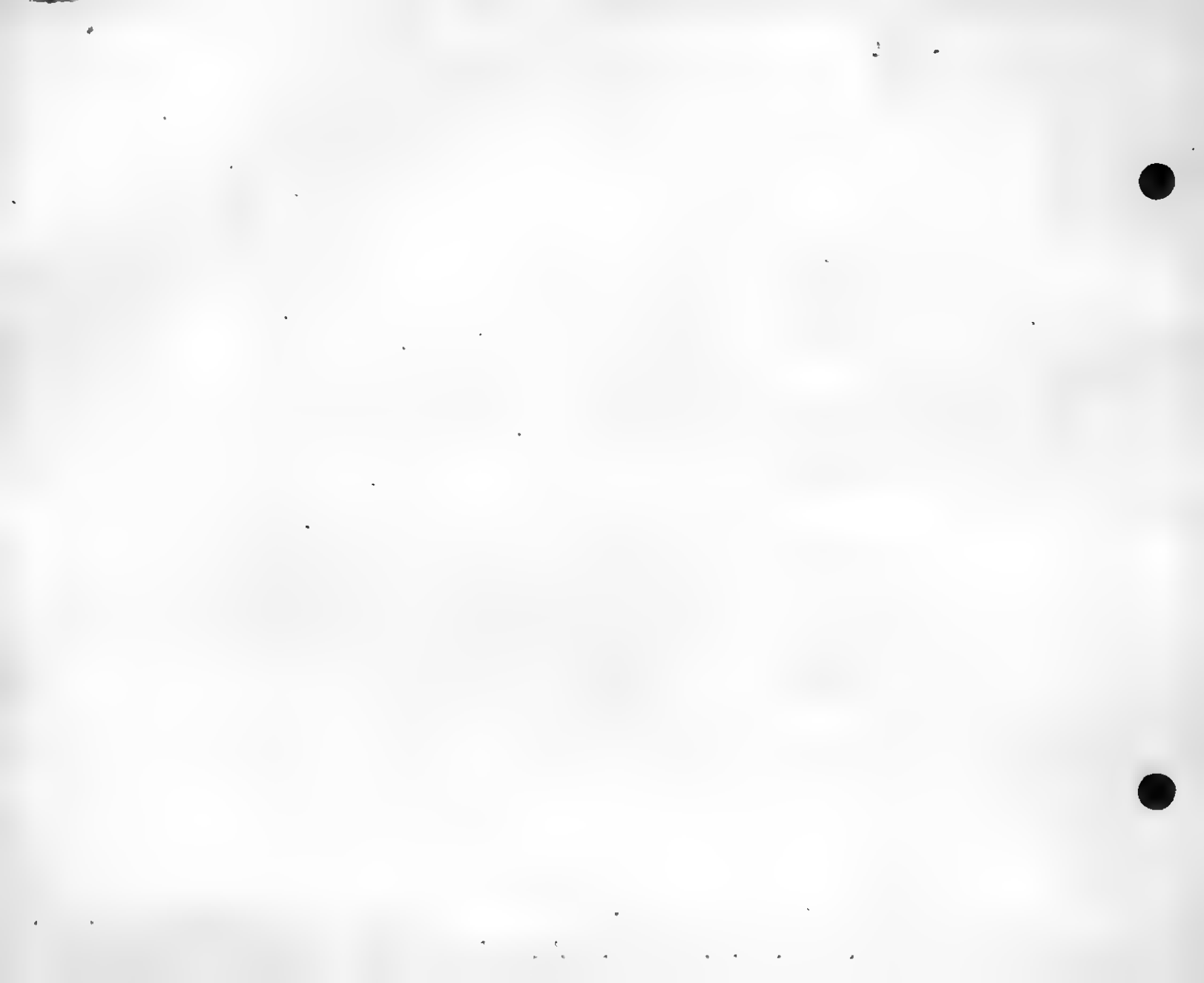
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundas</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4407 Franklin St.</u>	
3. NAME OF DECEASED (Type or print) <u>Agnes Madden Brew</u>		4. DATE OF DEATH <u>5-26-1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-79</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
10a. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		10b. CITIZEN OF WHAT COUNTRY?	
11. FATHER'S NAME <u>Michael Madden</u>		12. MOTHER'S MAIDEN NAME <u>Catherine Duke</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		14. SOCIAL SECURITY NO. <u>NONE</u>	
15. INFORMANT <u>MRS. Joseph Hockley</u>		Address <u>4407 Franklin St. Kensington Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>64</u> to <u>5-25-1966</u> , and that death occurred at <u>9:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>C P Ryland</u>		22b. DATE SIGNED <u>5-26-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>C P RYLAND</u>		22d. ADDRESS <u>4400 49 St NW Wash DC 20014</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-28-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons Inc.</u>		25a. RECEIVED BY REGISTRAR <u>Charles Judge</u>	
5130 Wisc. Ave. N.W., Wash. D.C.		DATE <u>JUN 2 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C7085

37075

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WHEATON NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>VA-Virginia</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ALEXANDRIA</u> d. STREET ADDRESS <u>8716 OAKLEAF DR</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY AGUSTA BRIDGETT</u> First Middle Last 4. DATE OF DEATH <u>MAY 8 1966</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>MAR 27-1892</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>Thad Parker</u> 14. MOTHER'S MAIDEN NAME <u>MARY A. PARKER</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Francis D. Bridgett, Alexandria, Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 MC</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1 March 1966</u> to <u>8 May 1966</u> that (I) <u>(was)</u> last saw the deceased alive on <u>2 May 1966</u> and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Walter Gooch</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>WALTER GOOCH MD</u> 22d. ADDRESS <u>2340 GLENNMONT CIR WHEATON MD</u>		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5-12-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> 23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. 517 11th St. S. E.</u> 25a. REC'D BY REGISTRAR <u>MAY 11 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07086

07076

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Bethesda.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda.</u>	
c. LENGTH OF STAY IN 1b <u>26 1/2 hr.</u>		d. STREET ADDRESS <u>5028 Westpath Terrace.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Potomac River at Little Falls Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>P.</u> Last <u>Brobeck</u>	4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1966</u>	5. SEX <u>M.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Sept. 27, 1952</u>		9. AGE (in years last birthday) <u>13</u> yrs. <u>7</u> Months <u>18</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Wayne P. Brobeck</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Rohrer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Father</u> Address <u>Same as Item 2.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Drowning -</u> DUE TO (b) <u></u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Swimming in River - caught in undertow - fallen.</u>	
20c. TIME OF INJURY Month, Day, Year <u>1:30 p.m. 5/15/1966</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Potomac River</u>		20f. (City or town) <u>Bethesda, Mont. Md.</u> (County) <u></u> (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>5/16/66</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		23b. DATE THEREOF <u>5-18-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Town Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Strasburg, Penna.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAY 19 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE
HEALTH DEPT.

07087

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07077

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8023 Eastern Ave.</u>		d. STREET ADDRESS <u>8023 Eastern Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Annie Marie Bronson</u>		4 DATE OF DEATH Month <u>5</u> Day <u>2</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April <u>19</u> , 1915 <u>51</u> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11 BIRTHPLACE (State or foreign country) <u>New York</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Burton L. Bronson</u>		14 MOTHER'S MAIDEN NAME <u>Louise E. Raymond</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>Yes</u>	
17. INFORMANT <u>Watertown, New York</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute asphyxiation due to aspiration</u> DUE TO (b) <u>of gastric contents.</u> DUE TO (c) <u>lost</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Deceased vomited and aspirated gastric contents.</u>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year <u>9:00</u> Hour <u>20</u> min <u>4/30</u> 19 <u>66</u>		20d PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Home</u>	
20e INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20f (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>Md.</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Golden R. Reap, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELOEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <u>Wharton</u>		22. DATE SIGNED <u>May 2, 1966</u>	
Address (Street, City, Town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>May 7, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	23d LOCATION (City or Town) <u>Watertown, New York</u> (County) (State)
24 FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a REC'D BY REGISTRAR <u>MAY 5 1966</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hyattsville</u>	
c. LENGTH OF STAY in 1b <u>14 days 10 1/2 hrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>8127 14th Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Lillian</u> Last <u>Buckland</u>		4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1893</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bud Hodge</u>		14. MOTHER'S MAIDEN NAME <u>Rexie Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 446X DUE TO <u>Nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Generalized arteriosclerosis</u> (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute diverticulitis of colon with hemorrhage</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <u>4/30</u> , 19 <u>66</u> , to <u>5/15</u> , 19 <u>66</u> , that (we) last saw the deceased alive on <u>5/15</u> 19 <u>66</u> , and that death occurred at <u>2:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Jules I. Cahan</u>		22b. DATE SIGNED <u>5/15/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JULES I. CAHAN, M.D.</u>		22d. ADDRESS <u>WASH. SAN & HOSP. TAKOMA PK. MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5/18/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sunset</u>		23d. LOCATION (City, town or county) (State) <u>Beckley West Va.</u>	
24. FUNERAL DIRECTOR <u>Keyser-Bryant</u>		25a. REC'D BY REGISTRAR <u>MAY 17 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07089

CERTIFICATE OF DEATH

07079

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>COITNEY</u> c. LENGTH OF STAY IN TB <u>3 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BROOKGROVE FOUNDATION</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>District of Columbia</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u> d. STREET ADDRESS <u>2800 Quebec St N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WIRTH EVANGELINE BULL</u> First Middle Last		4. DATE OF DEATH <u>May 28 1966</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-20-87</u> 9. AGE (in years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>HOWARD County-INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Nicholas Loop</u>		14. MOTHER'S MAIDEN NAME <u>Gillian Bradley Loop</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Glen C. Bull, Jr.</u> Address <u>#2 ABOVE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4221</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Anterior salivary gland duct disease</u> DUE TO <u>10 yr</u> (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>66</u> , to <u>May</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 28</u> , 19 <u>66</u> , and that death occurred at <u>11:20 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>A. D. Bohifant</u> 22c. PHYSICIAN'S NAME (Type) <u>A. D. BOHIFANT</u>		22b. DATE SIGNED <u>May 28 1966</u> 22d. ADDRESS <u>Sandy Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5/31/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>KOKOMO, INDIANA</u>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOSEPH GAWLIK'S SONS, INC.</u> <u>Joseph Gawlik Sons</u>		25a. REC'D BY REGISTRAR <u>JUN 3 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

MEDICAL CERTIFICATION

<div> <div>1</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>07080</div> </div> <div> <div>07080</div> <div>10am / 11am 5/6 5/16/66 - mn</div> </div>																							
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b						2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>4733 Bradley Blvd., Apt. 1</u>																	
3. NAME OF DECEASED (Type or print) <u>WILLIAM ANDREW BURNS</u>						4. DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>1966</u>																	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 14, 1913</u>		9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?											
13. FATHER'S NAME <u>James P. Burns</u>				14. MOTHER'S MAIDEN NAME <u>Hennetta Keenan</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW II</u> (If yes give year of discharge or service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>James P. Burns, Cumb. Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO (b) <u>Coronary Artery Heart Disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town)			(County)		(State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>																	
EXAMINER'S NAME (Type) <u>BELOEN R. REAP, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>5/6/66</u>						22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter & Paul</u>						22d. LOCATION (City, town, or county) <u>Cumberland Md</u> (State)					
23. FUNERAL DIRECTOR <u>Louis Stein Inc.</u>						ADDRESS <u>Cumb. Md</u>						24a. REC'D BY REGISTRAR <u>MAY 9 1966</u>						24b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>					

CERTIFICATE OF DEATH

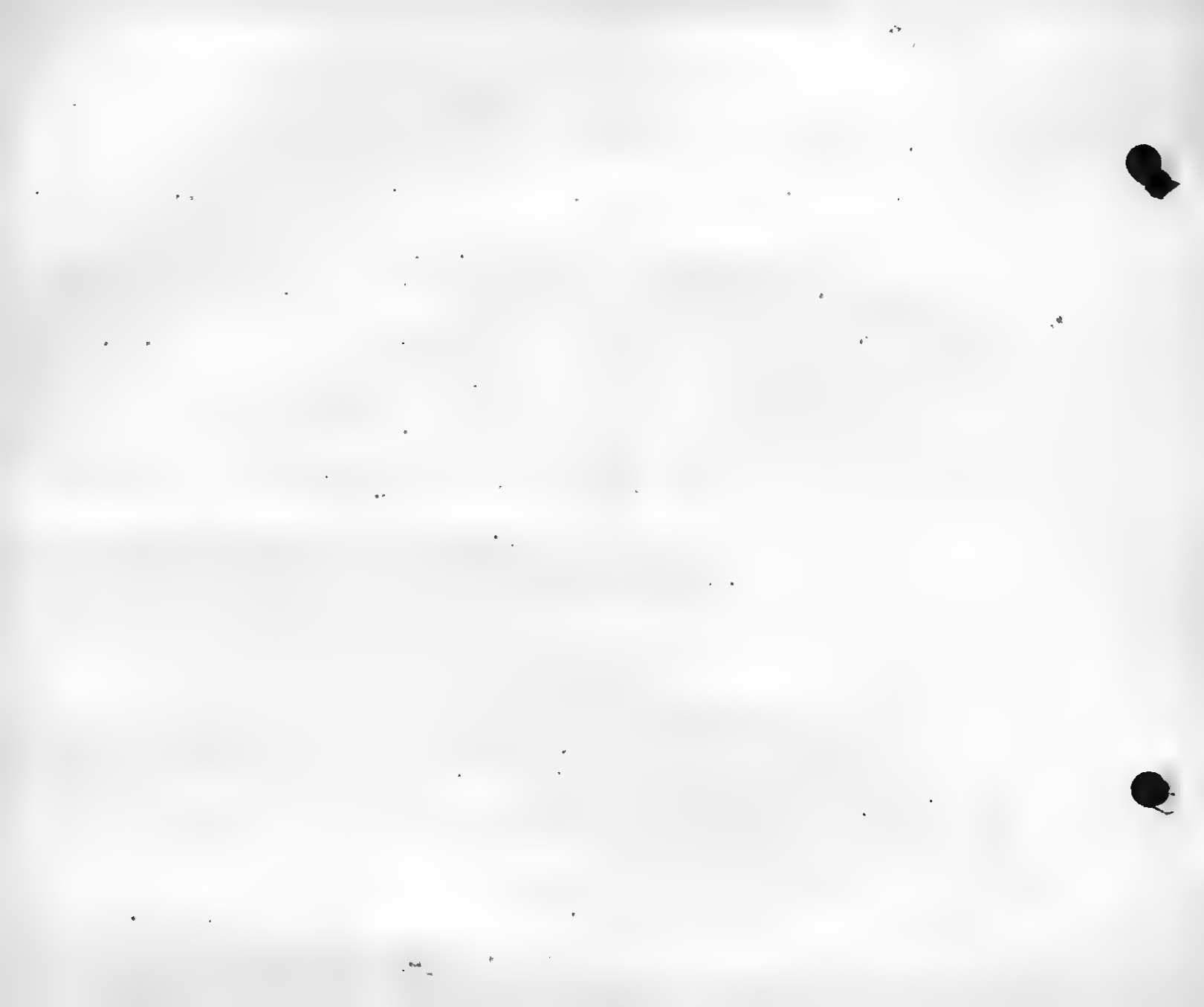
Reg. Dist. No.

C7081

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8903 Brookeville Road.,		d. STREET ADDRESS 8903 Brookeville Road.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Carter, Martha Edna		4. DATE OF DEATH Month Day Year May 14 1966	
5. SEX female 6. COLOR OR RACE col. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 10, 1901	
9. AGE (In years last birthday) 64 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Brown		14. MOTHER'S MAIDEN NAME Charlotte Scott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT William K. Carter: Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Disease 14-4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocardial Disease DUE TO (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 2-3	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 7 , 19 45 to May 14 , 19 66 that I last saw the deceased alive on April 11 , 19 65 , and that death occurred at 6:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John L. Rogers, M.D.		DATE SIGNED May 14, 1966	
PHYSICIAN'S NAME (Type) John L. Rogers			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/21/66	
22c. NAME OF CEMETERY OR CREMATORY Ash Memorial		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sworde		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR MAY 25 1966		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



C7092

CERTIFICATE OF DEATH

Reg. Dist. No.

C7082

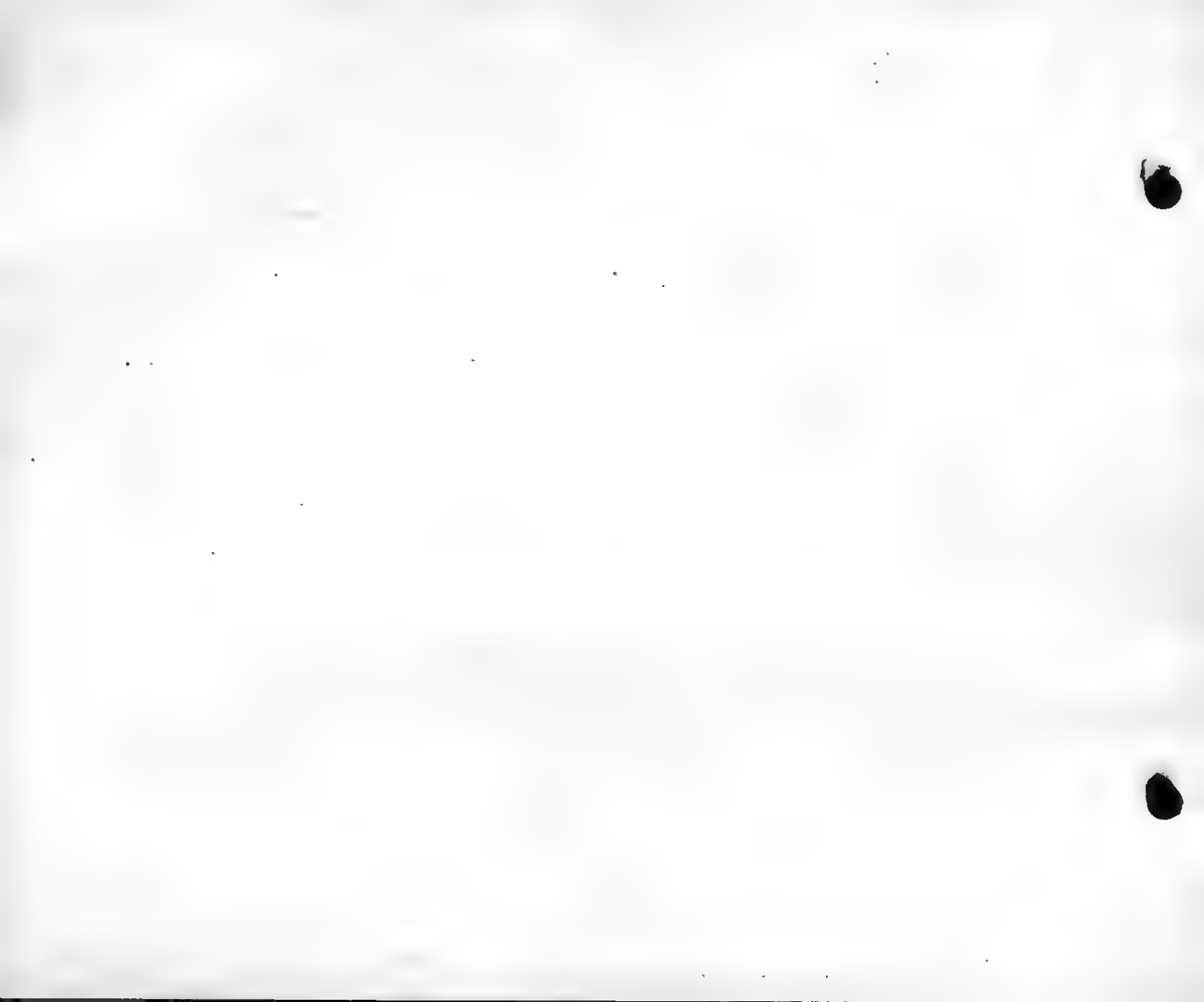
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9008 Fairview Rd.</u>				d. STREET ADDRESS <u>9008 Fairview Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Edna</u> Last <u>Casbarian</u>				4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 15 - 1898</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alfred H. Burdine</u>				14. MOTHER'S MAIDEN NAME <u>Mary Eliz. Lytle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>James Casbarian - 9008 Fairview Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>170X</u> DUE TO (b) <u>Carcinoma of Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Sept 65</u> <u>June 63</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct</u> 19 <u>65</u> , to <u>May</u> 19 <u>66</u> that I last saw the deceased alive on <u>May 29</u> 19 <u>66</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James W. Egan</u> M.D.				ADDRESS (Street, city or town, state) <u>5413 Cedar Lane - Bethesda, Md</u>			
DATE SIGNED <u>5/29/66</u>							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/1/66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company</u> ADDRESS <u>2901 14th St. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>JUN 2 1966</u>		24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 PLACE OF DEATH a COUNTY MONTGOMERY b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING					2 USUAL RESIDENCE (Where deceased lived f Institution Residence before admission) a STATE MARYLAND b COUNTY MONTGOMERY c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				
c LENGTH OF STAY IN 1b DOA					d STREET ADDRESS Whitmore Terrace 252 Woodbrook Road				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL					e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) First Katheryn Middle D. Last Chapman					4. DATE OF DEATH Month May Day 26 Year 1966				
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/15/01		9. AGE (In years last birthday) 65 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Consultant		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Pansy, Alabama			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME ABNER DAWSEY					14. MOTHER'S MAIDEN NAME EUGENIA WHIDDEN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO 266-38-3570		17. INFORMANT RALPH CHAPMAN-Husband Address 252 Whitmore Terrace Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO Acute Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Essential Hypertension. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Belden R. Reap M.D.					22. DATE SIGNED May 26, 1966				
EXAMINER'S NAME (Type) BELODEN R. REAP M.D.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 28 May 1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.			23d. LOCATION (City or town) (County) (State) Arlington, Virginia		
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. ADDRESS 8434 Georgia Avenue Silver Spring, Maryland					25a. REC'D BY REGISTRAR MAY 31 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



CERTIFICATE OF DEATH

C7094

C7085

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		c. LENGTH OF STAY IN 1b <u>2 Month 9 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairland Nursing Home</u>		d. STREET ADDRESS <u>5002 - 5th St., N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>(AKA) Maude Lee Clark Shreve</u>		DATE OF DEATH <u>May 14 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 18 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grant's Store</u>	11. BIRTHPLACE (Country & State, or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>John J. Finks</u>		14. MOTHER'S MAIDEN NAME <u>Sarah V. Groves</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>578-07-9520</u>	17. INFORMANT <u>Mrs. Gertrude V. Clark</u> (above address)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Insufficiency</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerotic Vascular Disease</u> DUE TO (c) <u>Brain</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/5</u> , 19 <u>66</u> , to <u>5/14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/14</u> , 19 <u>66</u> , and that death occurred at <u>5:4</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>		22b. DATE SIGNED <u>5-14-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		22d. ADDRESS <u>217 Union Bluffe, S.E. Sp. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/17/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Wash., D.C.</u>
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR <u>May 18 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

<div>Items 18-21 Fill in G5787 MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div>													
67095						MEDICAL EXAMINER'S CERTIFICATE OF DEATH						67086	
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San & Hospital</u>						2 USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> d. STREET ADDRESS <u>10225 Riggs Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Clifford Joe Clayton</u> First Middle Last 5 SEX <u>male</u> 6 COLOR OR RACE <u>White</u> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8 DATE OF BIRTH <u>1-15-47</u> 9 AGE (In years last birthday) <u>19</u> yrs F UNDER 1 YEAR Months <u>5</u> Days <u>14</u> F UNDER 24 HRS Hours <u>19</u> Min.													
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACT. BY ENLISTED</u> 10b KIND OF BUSINESS OR INDUSTRY <u>US ARMY</u> 11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, DC</u> 12 CITIZEN OF WHAT COUNTRY <u>U.S.</u>													
13. FATHER'S NAME <u>Clifford Talmadge CLAYTON (LIVING)</u> 14. MOTHER'S MAIDEN NAME <u>Jane Rainey</u>													
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>Apr 20-66</u> <u>213-46-9411</u> 16 SOC. A. SECURITY NO. <u>213-46-9411</u> 17. INFORMANT <u>Clifford Talmadge CLAYTON/FATHER/SEE ITEM #1</u> Address													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lacerations right Ventricle & Multiple</u> <u>11/14</u> DUE TO <u>Traumatic Injuries.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>Deceased, drag racing, lost control of car and crashed through bridge rail.</u> 20c TIME OF INJURY Month, Day, Year <u>5/14 19 66</u> 20d INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input checked="" type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u> 20f (City or town) <u>Adelphi</u> (County) <u>P. G.</u> (State) <u>md.</u>													
21 I certify that I took charge of the remains described above, had an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input type="checkbox"/> <u>Accident</u> <input checked="" type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Belden R. Read M.D.</u> EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u> 22. DATE SIGNED <u>May 14, 1966</u>													
23a BURIAL, CREMATION OR MOVING (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>5/17/1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL Cem.</u> 23d. LOCATION (City or Town) <u>ARLINGTON, VA.</u> (County) <u>VA.</u> (State)													
24 FUNERAL DIRECTOR <u>W.W. CHAMBERS INC. - SILVER SPRING MD</u> ADDRESS <u>5111 SILVER SPRING RD</u> 25. RECEIVED BY REGISTRAR <u>MAY 18 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>													

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07096

07087

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>			
c. LENGTH OF STAY IN 1b. <u>35 min.</u>				d. STREET ADDRESS <u>805 Herwin Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Holly</u> Middle <u>Anny</u> Last <u>Colie</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>14</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-28-65</u>	
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u>		IF UNDER 24 HRS. Hours <u>16</u> Min. <u>16</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Bill Colie</u>				14. MOTHER'S MAIDEN NAME <u>Elfriede Sorgel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Record-Washington San. + Hosp. Takoma Park, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Defect & cleft palate</u> <u>7545</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Pneumonitis</u> (c), stating the underlying cause last, DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 14, 1966</u> , to <u>May 14, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 14, 1966</u> , and that death occurred at <u>6:50</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Allen S. Gardner, M.D.</u>				22b. DATE SIGNED <u>May 15, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Allen S. Gardner, M.D.</u>	
22d. ADDRESS <u>1807 Eldon Lane Silver Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>17 May 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>MAY 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

C709

C7088

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before adm ssion) a. STATE Maryland b. COUNTY Annapolis	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN Tb 35 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 53 Cornhill Street	
3. NAME OF DECEASED (Type or print) First Mary Middle Linville Last Collins		4. DATE OF DEATH Month May Day 3 Year 1966	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 18, 1904
9. AGE (in years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 3 Days 1966	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Linville		14. MOTHER'S MAIDEN NAME Jennie Collins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 213 34 8684	
17. INFORMANT Annapolis, Maryland		18. Capt. Ross F. Collins, 53 Cornhill St., /	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4341 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of breast with widespread metastasis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Mar. 29 , 1966, to May 3 , 1966, that <input checked="" type="checkbox"/> (we) las saw the deceased alive on May 3 , 1966, and that death occurred at 755A M, from causes and on the date stated above			
22a. SIGNATURE Robert C. Cochran		22b. DATE SIGNED May 3, 1966	
22c. PHYSICIAN'S NAME (Type) Ge Robert C. Cochran, M. D.		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REBURY (Specify)	23b. DATE THEREOF 5/5/1966	23c. NAME OF CEMETERY OR CREMATORY U.S. Naval Academy	23d. LOCATION (City or Town) (County) (State) Annapolis, Maryland
24. FUNERAL DIRECTOR John M. Taylor & Sons, 147 Duke of Gloucester St. Annapolis, Md.		25. MAY 9 1966 Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville Hd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby Girl L. Colson</u>				4. DATE OF DEATH Month <u>5</u> Day <u>2</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/28/66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		9. AGE (In years last birthday) yrs. <u>4</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Md.</u>	
13. FATHER'S NAME <u>Kenneth Colson</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Combs</u>			
16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>J. Foxey</u> Address <u>-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>10/11</u> DUE TO (b) <u>Post-operative repair of meningomyelocele</u> DUE TO (c) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>-</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/28</u> , 19 <u>66</u> to <u>5/2</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>5/2</u> , 19 <u>66</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Marvin J. Mones</u>				22b. DATE SIGNED <u>5/2/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>MARVIN MONES</u>				22d. ADDRESS <u>1110 Spring St Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5-4-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		23d. LOCATION (City, town or county) (State) <u>MD</u>	
24. FUNERAL DIRECTOR <u>Charles Judge</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
ADDRESS <u>1110 Spring St Silver Spring Md</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

C7095

07090

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Northumberland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Paxinos</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Box 84</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First Middle Last <u>Conbere</u>		4. DATE OF DEATH <u>5-5-66</u> Month Day Year	
5. SEX <u>M.</u>	6. CO. OR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-01</u> 64 yrs.
9. AGE (in years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>7</u> IF UNDER 24 HRS: Hours <u>6</u> Min <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>Movie Projectionist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Movies</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Shamokin Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Phill Conbere</u>		14. MOTHER'S MAIDEN NAME <u>Estherne Forbes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Wife Dorothy Conbere (lives alone)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>411X Congestive heart failure</u> DUE TO (b) <u>Rheumatic aortic valvulitis, chronic</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 1966</u> to <u>May 1966</u> . That (I) (we) lost the deceased alive on <u>4 May 1966</u> , and that death occurred at <u>6:45</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>John J. Pumphrey</u> M.D.		22b. DATE SIGNED <u>5 May 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN J. PUMPHREY</u>		22d. ADDRESS <u>4977 BATTERY LANE BETHESDA</u> M.D.	
23a. RURAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>transit 5/6/1966</u>	<u>St. Edwards Cemetery</u>	<u>Shamokin, Pennsylvania</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>May 9 1966</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
ISM 9/58

(M)

(1)

DB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Filed 5/27/66 6/7/66 mh

CERTIFICATE OF DEATH

Reg. Dist. No. 07092

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10225 Kensington Parkway Apt. 715		d. STREET ADDRESS 10225 Kensington Parkway Apt. 715	
3. NAME OF DECEASED (Type or print) First Marie Middle Louise Last Conner		4. DATE OF DEATH Month May Day 3 Year 1966	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/17/88 1882
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Richmond, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Stephenson		14. MOTHER'S MAIDEN NAME Ella D. Deupree	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 577-03-7281	
INFORMANT Kenneth Conner-2705 Byron St. S.Sp. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Carcinoma of breast with metastases DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 years 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/1 , 19 50 , to 5/3 , 19 66 , that I last saw the deceased alive on 5/3 , 19 66 , and that death occurred at 8:15 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE John E. Everett M.D.		ADDRESS (Street, city or town, state) 9400 Conn. Ave	
DATE SIGNED 5/3/66			
PHYSICIAN'S NAME (Type) JOHN E. EVERETT		Kensington, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5/6/66	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		ADDRESS Washington, D.C.	
24a. REC'D BY REGISTRAR MAY 5 1966		24b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

07102

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

37093

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b		2 USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>610 Bonifant Street</u>		d. STREET ADDRESS <u>610 Bonifant St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>MILTON Stanley COOLEY</u>		4 DATE OF DEATH Month <u>5</u> - Day <u>1</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan. 18, 1902</u> 9 AGE (In years last birthday) <u>64</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baileys Liquors</u>	11 BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u> 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13 FATHER'S NAME <u>Richard Cooley</u>		14 MOTHER'S MAIDEN NAME <u>Harriet Mast</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <u>no</u>		16 SOCIAL SECURITY NO <u>577-14-9310</u>	17. INFORMANT <u>Willie H. Cooley, Street., Silver Spring, Md.</u> Address <u>610 Bonifant</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>last</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 3, 1966</u> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 5, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>	23d. LOCATION (City or town) (County) (State) <u>Washington, D. C.</u>
24 FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>MAY 9 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

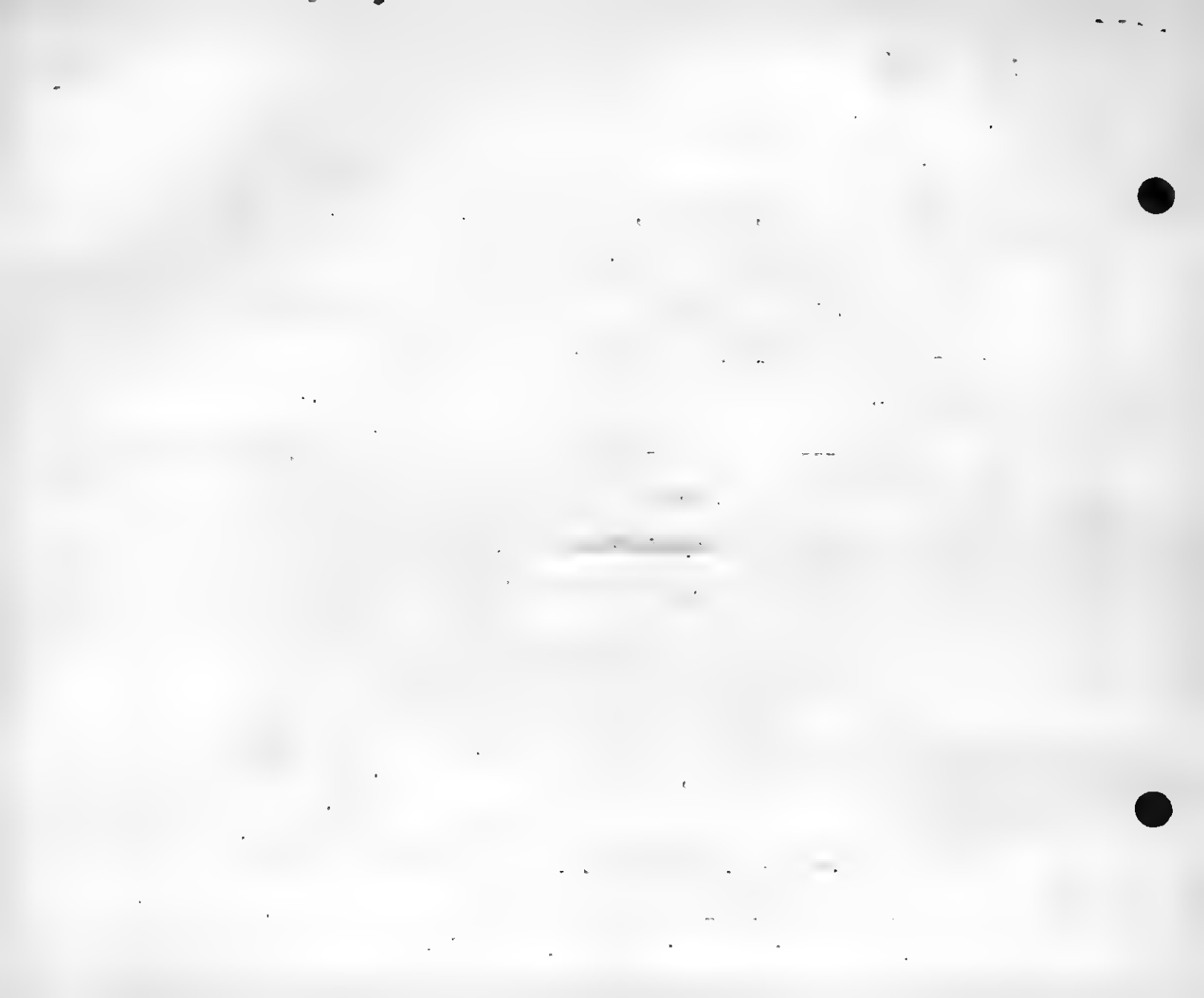


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
07094									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN ID 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Ohio b. COUNTY Barnesville c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Barnesville d. STREET ADDRESS 225 North Broadway Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Harold Dean Crum			4. DATE OF DEATH Month May Day 12 Year 1966						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 December 1911		9. AGE (In years last birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto-body repair worker			10b. KIND OF BUSINESS OR INDUSTRY Automotive		11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Harley Crum					14. MOTHER'S MAIDEN NAME Hattie Beabout				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 286-03-8048		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia 416X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Hepatic insufficiency DUE TO (c) Rheumatic heart disease								INTERVAL BETWEEN ONSET AND DEATH minutes 2 months 40 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that the (this hospital) attended the deceased from April 27 , 19 66 , to May 12 , 19 66 , that he (we) last saw the deceased alive on May 12 , 19 66 , and that death occurred at 12:20 , from the causes and on the date stated above.									
22a. SIGNATURE <i>William W. Parmley</i>					22b. DATE SIGNED May 12, 1966		22c. PHYSICIAN'S NAME (Type) William W. Parmley, M.D.		
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 5-13-66			23b. DATE THEREOF 5-13-66		23c. NAME OF CEMETERY OR CREMATORY Crestview Cemetery		23d. LOCATION (City, town or county) (State) Barnesville, Ohio		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY					25a. REC'D BY REGISTRAR MAY 17 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



CERTIFICATE OF DEATH

37095

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Pennsylvania</u> b COUNTY <u>York</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN "b" <u>52 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d STREET ADDRESS <u>305 Waring Road</u>	
3 NAME OF DECEASED (Type or print) <u>Edwin</u> First Middle Last <u>Cubler</u>		4 DATE OF DEATH <u>may 14 1966</u> Month Day Year	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/06/02</u>
9 AGE (In years to birthday) <u>63</u> yrs		10 UNDER 1 YEAR <u>6</u> Months <u>8</u> Days <u>11</u> Hours <u>19</u> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Project Manager</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Balto. Construct. Co</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Phila Pa</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Jacob Cubler</u>		14 MOTHER'S MAIDEN NAME <u>Sarah ?</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>Unknown</u>	
17 INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarct, myocardial, massive</u> DUE TO (b) <u>Arteriosclerosis, coronary, severe</u> DUE TO (c) <u>Anteroseclerosis, coronary, severe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVA. BETWEEN ONSET AND DEATH <u>Weeks</u> <u>Years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Confluent lobular pneumonia, fatal</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-13-66</u> , 19 <u>66</u> , to <u>5-13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-13-66</u> , and that death occurred at <u>2:15 A.M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>Robert R. Montgomery</u>		22b DATE SIGNED <u>5-14-66</u>	
22c PHYSICIAN'S NAME (Type) <u>ROBERT R. MONTGOMERY</u>		22d ADDRESS <u>5411 CEDAR LANE BETHESDA MD</u>	
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
<u>Burial-transit</u>	<u>5-15-66</u>	<u>West Laurel Hill</u>	<u>Chesapeake Beach</u>
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		25a REC'D BY REGISTRAR <u>MAY 17 1966</u>	
25b REGISTRAR'S SIGNATURE <u>Bethesda, Maryland</u>		<u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
211 M 1/66

07105

CERTIFICATE OF DEATH

07096

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN lb 20 days		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD b. COUNTY MONT. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) RESMOR 570 CRANSWORTH LA. NURSING HOME		d. STREET ADDRESS 10021 DICKENS AVE	
3 NAME OF DECEASED (Type or print) First Middle Last PAUL J. CURRAN		4 DATE OF DEATH Month Day Year MAY 31 1966	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 B DATE OF BIRTH 10-19-94
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER (RETIRED)		10b KIND OF BUSINESS OR INDUSTRY MARYLAND	9 AGE (in years last birthday) 71
13 FATHER'S NAME HUGH CURRAN		14 MOTHER'S MAIDEN NAME ANNA MC MASTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 276-10-7694	
17 INFORMANT Mrs. Rebecca B. Curran		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) SOIX DUE TO Cerebrovascular Accident (b) Cerebral arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Immediate ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1, 1966 to May 31, 1966 , that (I) (we) last saw the deceased alive on 5-24-1966 , and that death occurred at 5:14 A.M. from causes on and on the date stated above.			
22a. SIGNATURE George A. Gray, Jr.		22b. DATE SIGNED 5/31/66	
22c. PHYSICIAN'S NAME (Type) George A. GRAY, JR.		22d. ADDRESS 4140 Chevy Chase Dr. NW	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-3-66	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or town) (County) (State) Suitland Maryland	
24. FUNERAL DIRECTOR Francis J. Collins		25a. REC'D BY REGISTRAR JUN 2 1966	
ADDRESS Wash. DC 3821-14th St. NW		25b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

37097

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.C.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. San. & Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> d. STREET ADDRESS <u>2410 - Kirston St.</u>			
3. NAME OF DECEASED (Type or print) <u>Margaret Porter Curtin</u>		4. DATE OF DEATH Day <u>14</u> Month <u>May</u> Year <u>1966</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/26/1883</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ireland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Robert Porter</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Curran</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs. Joseph N. Curtin (above address) (Daughter)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Degenerative Cardio-vascular disease</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>5 years</u>			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 1968</u> , to <u>May 14, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 13, 1966</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Herbert G. Brandes</u>		22b. DATE SIGNED <u>May 18 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Herbert G. Brandes, M.D.</u>			
22d. ADDRESS <u>3400 University Blvd East Adelphi, Maryland</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/17/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>			
23d. LOCATION (City, town or county) <u>Wash., D.C.</u>		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home Inc.</u>		24b. ADDRESS <u>Mt. Rainier Maryland</u>		25a. REC'D BY REGISTRAR <u>MAY 18 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared to medical examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07107											
67098											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Althea Woodland Nursing Home, 1000 Daleview Dr.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8500- Dixon Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Marie</u> First <u>Katharin</u> Middle <u>Katharin</u> Last <u>Cutler</u>			4. DATE OF DEATH Month <u>5</u> Day <u>20</u> Year <u>1966</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>white</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>June 5, 1879</u>			9. AGE (In years last birthday) <u>86</u> yrs.			10. IF UNDER 1 YEAR Months <u>5</u> Days <u>20</u> Hours <u>19</u> Min. <u>66</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Rochester, New York</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Henry Zahn</u>						14. MOTHER'S MAIDEN NAME <u>Anna M. Henning</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT <u>Mrs Gertrude Trainor</u> Address <u>#5 Sideside Rd. Silver Spring, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 351X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> OUE TO (c) <u>arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH. <u>few minutes</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19 <u>57</u> , to <u>May 20</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>May 19</u> , 19 <u>66</u> , and that death occurred at <u>7:30</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Raymond O. West</u>						22b. DATE SIGNED <u>May 20, 1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>Raymond O. West</u>						22d. ADDRESS <u>831-University Blvd. E. Hyattsville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>May 23, 1966</u>			23b. DATE THEREOF <u>May 23, 1966</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>						25a. REC'D BY REGISTRAR <u>MAY 24 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending in return" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

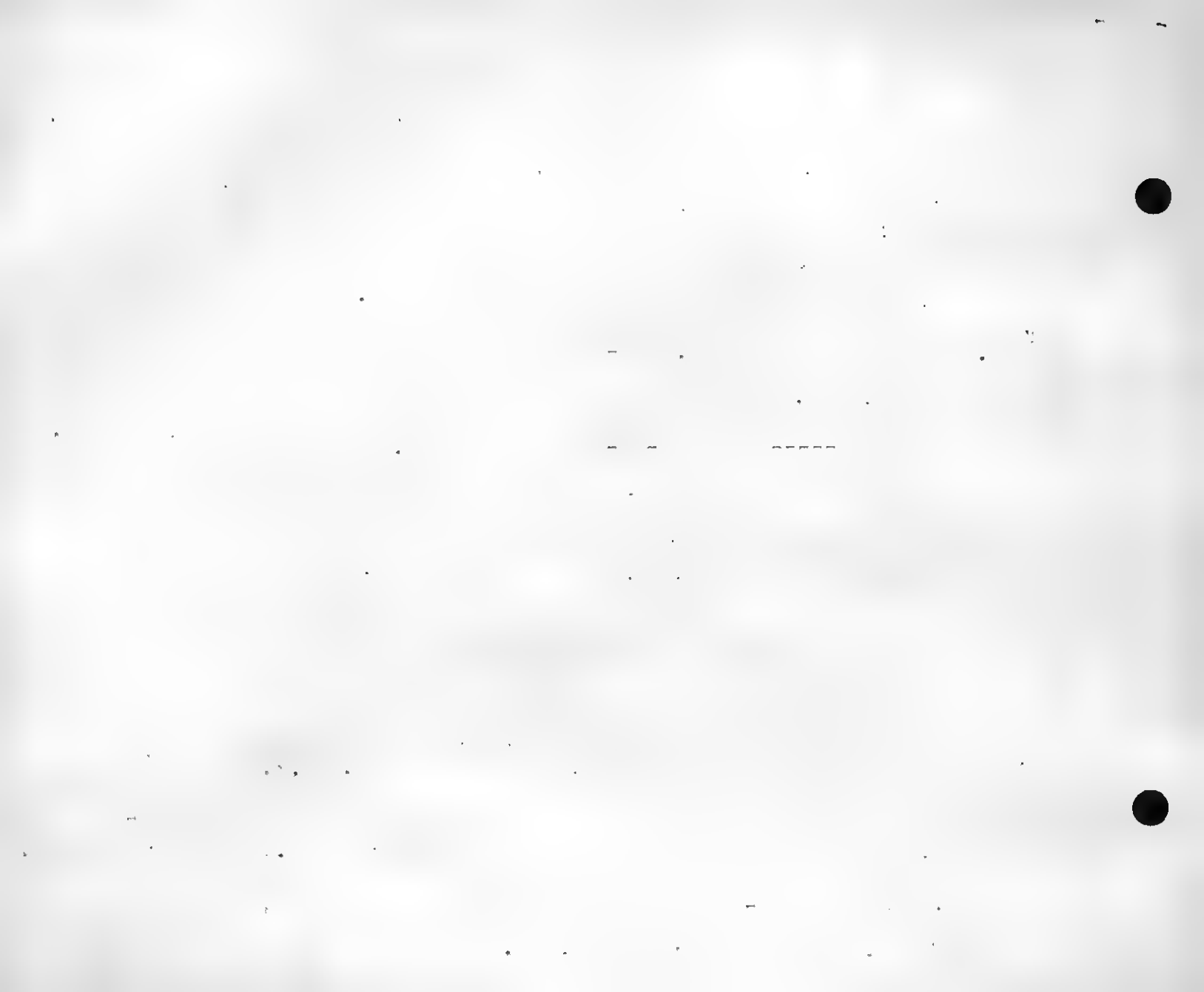
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN To <u>1 year</u> d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>2807 Univ. Blvd. West</u>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>2807 Univ Blvd. West</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>James Riddick Daniels</u> F. first M. middle L. last		4 DATE OF DEATH <u>5 - 10 19 66</u> Month Day Year	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-6-19 46</u> Month Day Year
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>Ret. Army Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ARMY</u>	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>James A. Daniels</u>	
14. MOTHER'S MAIDEN NAME <u>Hattie Hardison</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>Yes WW II</u>	
16. SOCIAL SECURITY NO. <u>210-20-6189</u>		17. INFORMANT <u>Jeanette M. Daniels (wife)</u> Address <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>4201</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>with recent Infarction;</u> DUE TO (c) <u>Coronary Artery Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap, M.D.</u> EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		22. DATE SIGNED <u>May 11, 1966</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>13 May, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REG. STRAR <u>MAY 16 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN 1b <i>3 1/2 days</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> d. STREET ADDRESS <i>4304 Randolph Road</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Middle Last <i>Glenn B Darnell</i>			4. DATE OF DEATH Month Day Year <i>May 19 1966</i>			5. SEX <i>M</i>			6. COLOR OR RACE <i>W</i>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <i>May 18, 1906</i>			9. AGE (In years, last birthday) <i>60 yrs.</i> Months Days Hours Min.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Custodian at School</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Jr. High-Sligo</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>Charles W. Darnell</i>			14. MOTHER'S MAIDEN NAME <i>Sophie McVey</i>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No -----			16. SOCIAL SECURITY NO. <i>244-09-2670</i>		
17. INFORMANT <i>Wife</i>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Glenn negative Septicemia due to</i> DUE TO <i>Prostatic Surgery</i> (b) <i>Prostatic Hypertrophy</i> DUE TO (c)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <i>30 days</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>15 May</i> , 19 <i>66</i> , to <i>19 May</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>19 May</i> , 19 <i>66</i> , and that death occurred at <i>3:35 A.M.</i> , from the causes and on the date stated above.														
22a. SIGNATURE <i>Joseph Bloom</i>						22b. DATE SIGNED <i>5-19-66</i>			22c. PHYSICIAN'S NAME (Type) <i>JOSEPH BLOOM</i>			22d. ADDRESS <i>1015 Spring St., Silver Spring, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>5-23-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sherwood Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Salem, Virginia</i>				
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY</i>						ADDRESS <i>Bethesda, Md.</i>			25a. REC'D BY REGISTRAR <i>MAY 23 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



C7110

CERTIFICATE OF DEATH

07102

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 3 days		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY Florida Santa Rosa		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milton		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 341 Merrill Drive		b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Michael Paul DAVIS		First		Middle		Last		4. DATE OF DEATH May 19 1966		Month		Day		Year	
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 7 Jan 1966		9. AGE (In years last birthday) yrs 07 12		F UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY NA				11. BIRTHPLACE (Country & State or foreign country) Florida				12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME William Joseph DAVIS								14. MOTHER'S MAIDEN NAME Margaret Hardman William J. DAVIS Milton, Florida							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. NA				17. INFORMANT William J. DAVIS Milton, Florida				18. ADDRESS 341 Merrill Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 1545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Congestive Heart Failure & Poor Pulmonary Respiration DUE TO (c) Turncus Arteriosis (Congenital Heart Disease)												INTERVAL BETWEEN ONSET AND DEATH 3 minutes 3-4 weeks 4 mo 12 da			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that he (this hospital) attended the deceased from 17 May , 1966, to 19 May , 1966, that he (we) last saw the deceased alive on 19 May , 1966, and that death occurred at 8:07 PM , from causes and on the date stated above.															
22a. SIGNATURE E. G. Brown								M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 19 May 1966			
22c. PHYSICIAN'S NAME (Type) E. G. BROWN, LT MC USN								22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit				23b. DATE THEREOF 5-20-66				23c. NAME OF CEMETERY OR CREMATORY Linwood Cemetery				23d. LOCATION (City or Town) (County) (State) Cedar Rapids, Santa Rosa Iowa			
24. FUNERAL DIRECTOR 7557 Wisconsin Ave., Bethesda, Md. R.A. PUMPHREY Funeral Home								25a. REC'D BY REGISTRAR MAY 25 1966				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 818 DAVIS AVENUE		e. STREET ADDRESS 818 DAVIS AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First RUTH Middle B. Last DAVIS		4 DATE OF DEATH Month MAY Day 1 Year 1966	
5 SEX F	6 COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/30/98
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STENOGRAPHER		10b. KIND OF BUSINESS OR INDUSTRY FED. GOVT. (RET.)	
11. BIRTHPLACE (State or foreign country) CORNING, IOWA		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES MONROE BELKNAP		14. MOTHER'S MAIDEN NAME JENNIE BLACK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-444578	
17. INFORMANT MRS. KATHERINE B. NICHOLS - BUFFALO, N.Y.		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEPATIC FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTATIC MALIGNANCY - Adenocarcinoma of Stomach DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 WK 5 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from MARCH 3, 1966 to MAY 1, 1966 , that (I) (we) last saw the deceased alive on April 29, 1966 , and that death occurred at 9 P.M. from the causes and on the date stated above			
22a SIGNATURE Maurice A. Capone M.D.		22b DATE SIGNED 5/1/66	
22c PHYSICIAN'S NAME (Type) MAURICE A. CAPONE, M.D.		22d ADDRESS 5600 CROMWELL DRIVE, WASH 16, D.C.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCAT ON (City, town, or county) (State)
Burial	May 4, 1966	George Washington	Adelphi, Pr. Geo. Co. Md
24 FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters		25a REC'D BY REGISTRAR MAY 4 1966	
ADDRESS 254 Carroll St NW		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

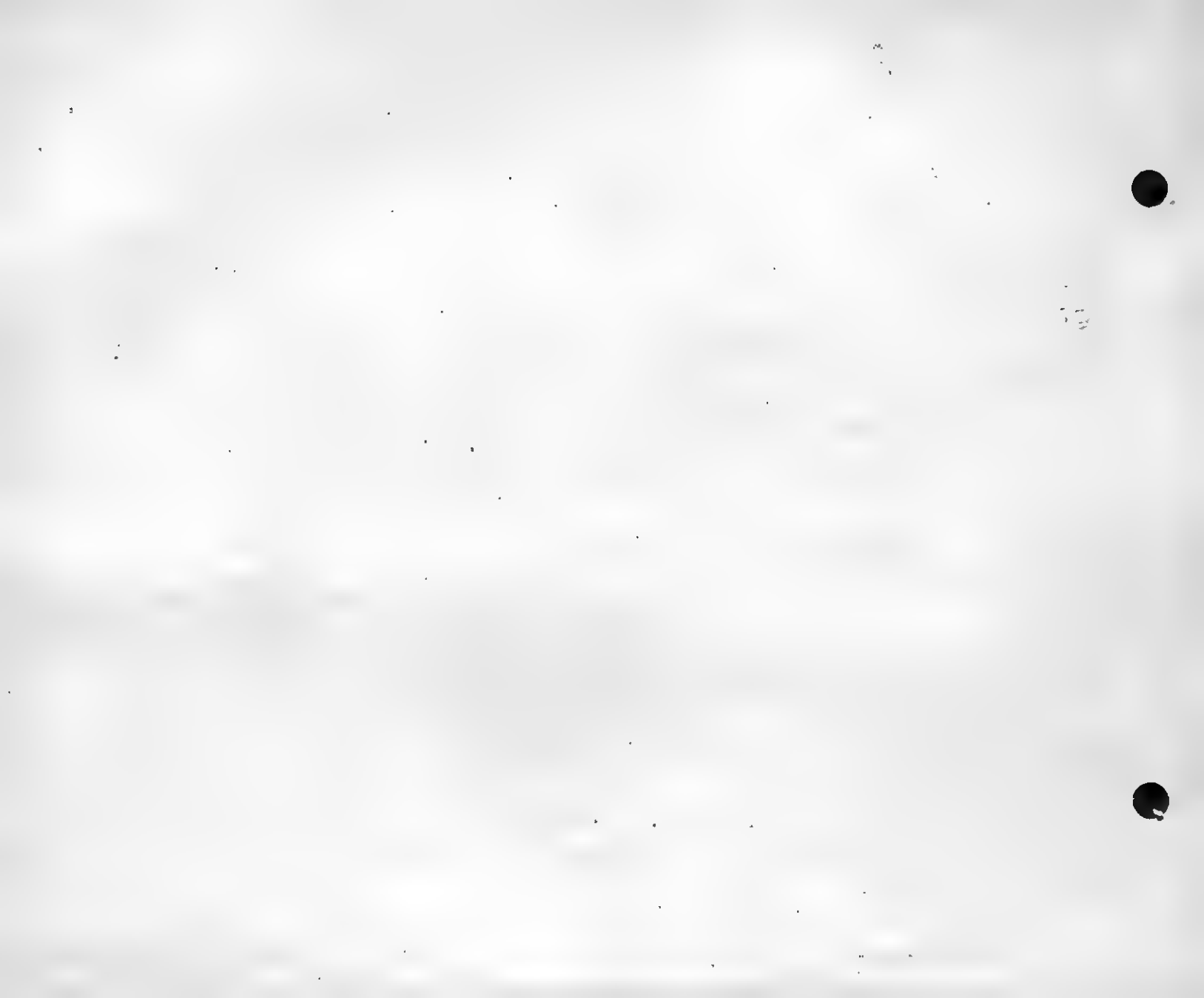
CERTIFICATE OF DEATH

07104

<p>1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Coxon Hill</u></p>			
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u></p>		<p>c. LENGTH OF STAY IN 1b <u>25 days - 4 hrs - 40 min</u></p>		<p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Coxon Hill</u></p>		<p>d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u></p>				<p>d. STREET ADDRESS <u>6324 Furness Ave</u></p>			
<p>3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Earl</u> Last <u>Dean</u></p>				<p>4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1966</u></p>			
<p>5. SEX <u>Male</u></p>		<p>6. COLOR OR RACE <u>White</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>9-12-00</u></p>	
<p>9. AGE (in years last birthday) <u>65</u> yrs.</p>		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>				<p>13. FATHER'S NAME <u>Unknown - Dean</u></p>			
<p>14. MOTHER'S MAIDEN NAME <u>Unknown</u></p>				<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u></p>			
<p>16. SOCIAL SECURITY NO. <u>Hospital Records</u></p>				<p>17. INFORMANT <u>7600 Carroll Ave.</u></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Emphysema - cor pulmonale</u> DUE TO (c) <u>Interstitial pulmonary fibrosis</u></p>							<p>INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>years</u> <u>years</u></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>							<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <u>4-7, 1966</u> to <u>5-3, 1966</u> that (I) (we) last saw the deceased alive on <u>5-3, 1966</u>, and that death occurred at <u>3:45</u> M. from the causes and on the date stated above.</p>							
<p>22a. SIGNATURE <u>Bleemeth Cruz</u></p>				<p>22b. DATE SIGNED <u>5/3/1966</u></p>			
<p>22c. PHYSICIAN'S NAME (Type) <u>Kenneth CRUZE</u></p>				<p>22d. ADDRESS <u>Washington Sanitarium & Hospital</u></p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>23b. DATE THEREOF <u>5/6/1966</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u></p>		<p>23d. LOCATION (City, town or county) (State) <u>Switzland</u></p>	
<p>24. FUNERAL DIRECTOR <u>Walter 131-11th St. S.E. D.C.</u></p>				<p>25a. REC'D BY REGISTRAR <u>Charles Judge</u></p>			
<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>				<p>DATE <u>MAY 6 1966</u></p>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

C7113

CERTIFICATE OF DEATH

07105

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURA. and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairland Nursing Home, Fairland Rd.</u>		d. STREET ADDRESS <u>1926 Locust Grove Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA Denning</u>		4. DATE OF DEATH Month Day Year <u>MAY 27 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/22/79</u>
9. AGE (In years last birthday) <u>87 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ill.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Jacob Denning</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Price</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Dr. Robert E. Smith</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Cerebral Insufficiency</u> DUE TO (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>9/1</u> , 19 <u>65</u> , to <u>5/27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/27</u> 19 <u>66</u> , and that death occurred at <u>9:45</u> P.M. from causes and on the date stated above.	
22a. SIGNATURE <u>Raymond T. Benack</u> M.D.		22b. DATE SIGNED <u>5/27/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond T. BENACK MD</u>		22d. ADDRESS <u>4115 Colie Drive Wheaton MD</u>	
23a. BURIAL - CREMATION REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>5/2/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cakes View Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Cakes, North Dakota</u>	
24. FUNERAL DIRECTOR <u>Cherry Chase Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Wash. D. C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>JUN 3 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

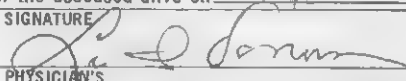
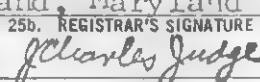
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.

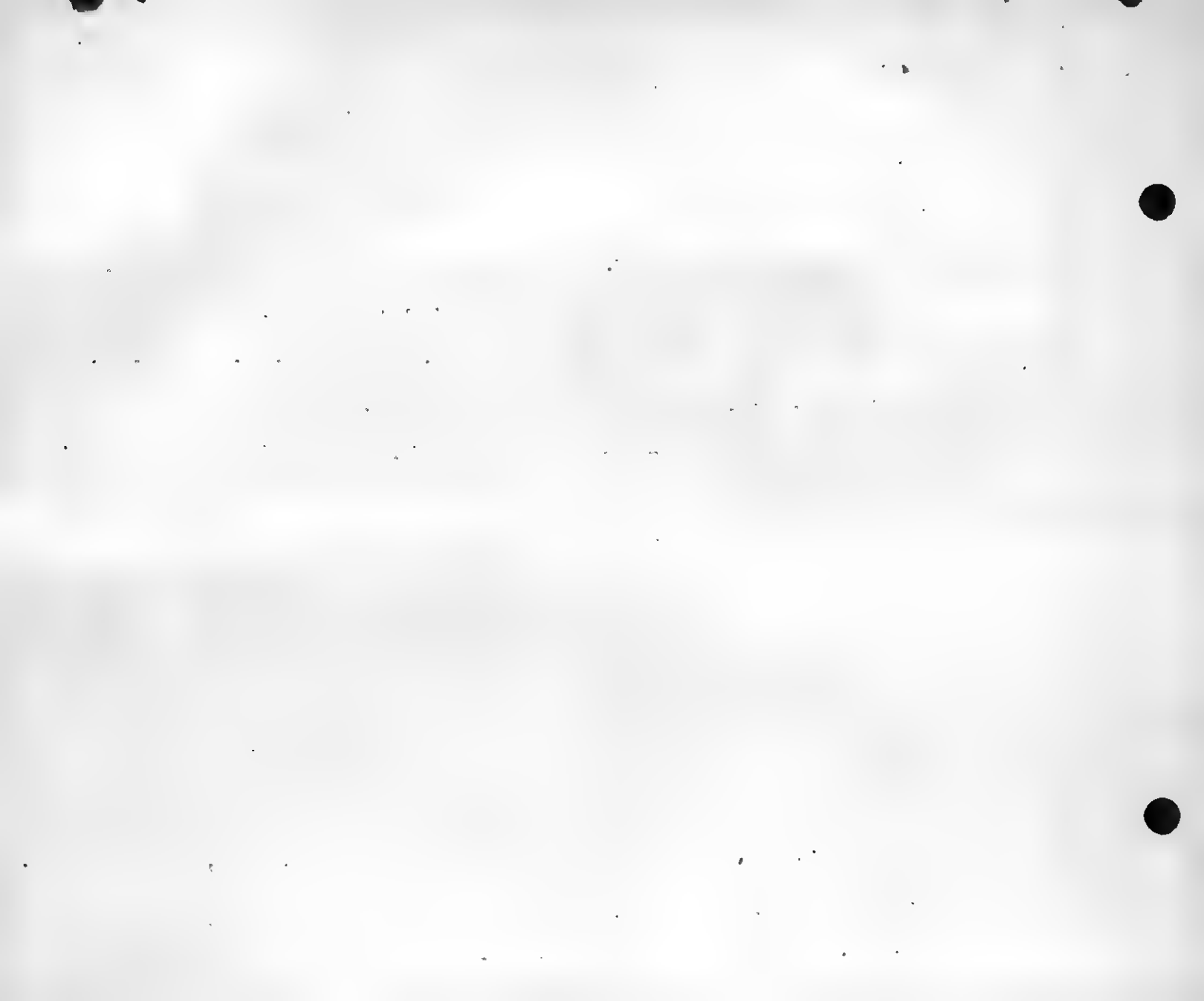


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
C7114					CERTIFICATE OF DEATH					07106				
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4627 Chestnut Street					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4627 Chestnut Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First JAMES Middle W. Last DENT					4. DATE OF DEATH Month May Day 11 Year 1966									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 6, 1900		9. AGE (in years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 8 Days 5		IF UNDER 24 HRS. Hours 5 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Part-Owner				10b. KIND OF BUSINESS OR INDUSTRY Glass Shop		11. BIRTHPLACE (County & State, or foreign country) Charles County, Md.				12. CITIZEN OF WHAT COUNTRY? U. S.				
13. FATHER'S NAME Thomas B. Dent					14. MOTHER'S MAIDEN NAME Daisy P. Hayden									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 577-09-4760		17. INFORMANT Brother Thomas C. Dent		Address Same as Item 2.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) TUBERCULOSIS LUNGS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 7 HRS 10 YRS				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from JAN , 19 54 , to MAY , 19 66 , that (I) (we) last saw the deceased alive on MAY 11 , 19 66 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.														
22a. SIGNATURE 								22b. DATE SIGNED 5-11-66						
22c. PHYSICIAN'S NAME (Type) LEO I. DONOVAN								22d. ADDRESS 8218 Wisconsin Ave, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-13-66		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City, town or county) (State) Suitland, Maryland						
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY						ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR MAY 17 1966		25b. REGISTRAR'S SIGNATURE 				



C7115

CERTIFICATE OF DEATH

07107

1 PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN IB 2 Days		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Virginia b COUNTY Arlington c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland		e STREET ADDRESS 857 North Liberty Street		f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Henry Thornton DIETRICH		4 DATE OF DEATH Month May Day 28 Year 1966			
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4 April 1904	9 AGE (In years last birthday) 62 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Sandusky, Ohio	
13 FATHER'S NAME George C. Dietrich		14 MOTHER'S MAIDEN NAME Louisa Talbott		12 CITIZEN OF WHAT COUNTRY? USA	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16 SOCIAL SECURITY NO. 300-34-8428		17 INFORMANT Katherine Dietrich Address 857 North Liberty Street Arlington, Virginia	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 26 May , 1966, to 28 May , 1966, that (I) (we) last saw the deceased alive on 28 May , 1966, and that death occurred at 2:40AM , from causes and on the date stated above.					
22a SIGNATURE James S. Shumaker		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b DATE SIGNED 28 May 66	
22c PHYSICIAN'S NAME (Type) James S. SHUMAKER		22d ADDRESS U.S. Naval Hospital, Bethesda, Maryland			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 1 Jun 66		23c NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Va.	
23d LOCATION (City or Town) (County) (State)					
24 FUNERAL DIRECTOR B. I. Jones		25a REC'D BY REGISTRAR May 31 1966		25b REGISTRAR'S SIGNATURE Charles Judge	

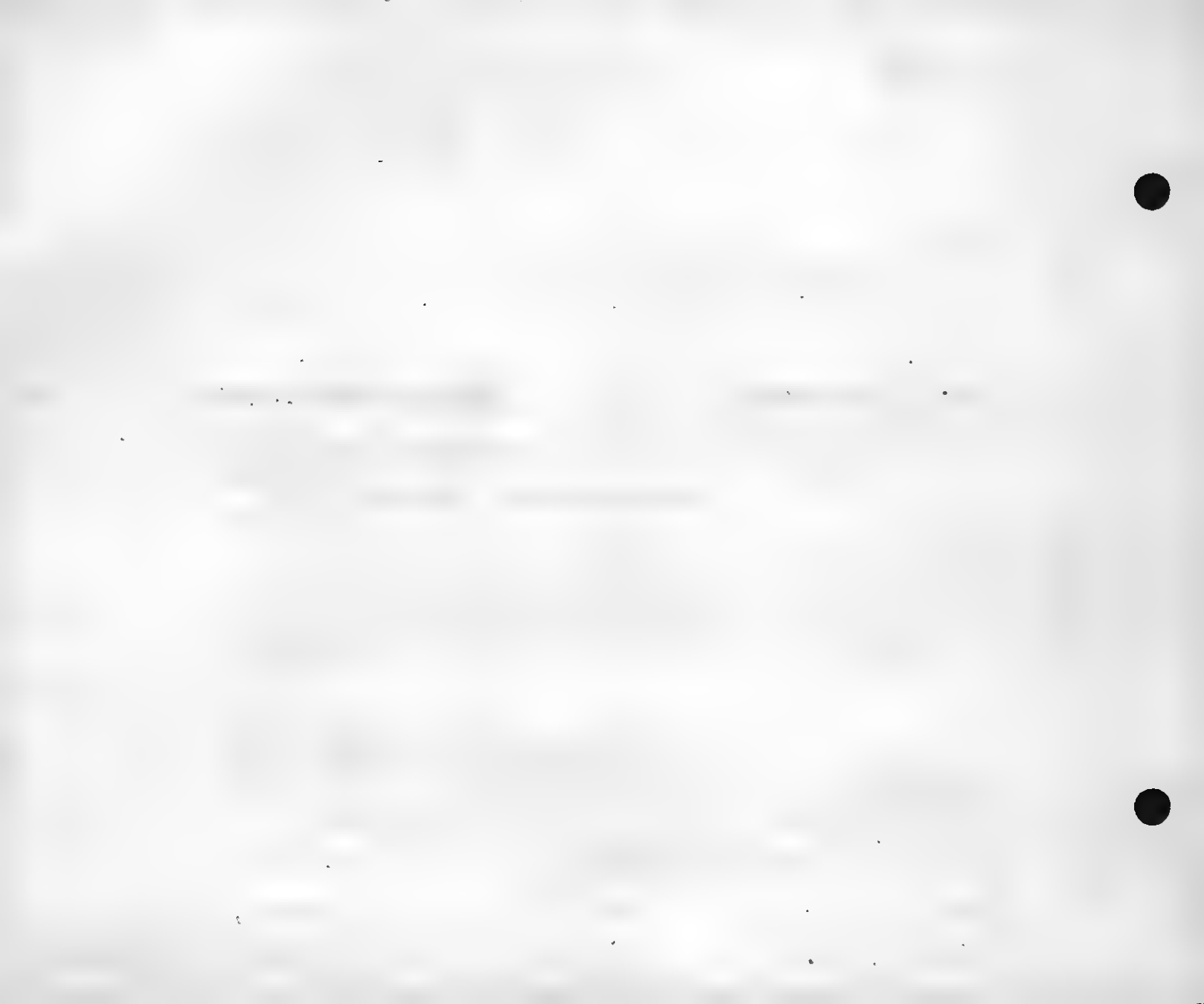
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or disposal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>20 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> 15-1 d. STREET ADDRESS <u>13108 Valleywood Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>C</u> Last <u>DITTO</u>						4. DATE OF DEATH Month <u>5</u> Day <u>26</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>97</u> 10-14-96		9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Louisville, Ky.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Charles Wesley Albany</u>						14. MOTHER'S MAIDEN NAME <u>Lillie C. Lyons</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>David Albany Ditto</u> Address <u>7125 Noland Rd. Falls Church, Va.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GRAM-NEGATIVE BACTERIAL PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Miliary Tuberculosis</u> (c) <u>DIABETES MELLITUS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5/7/66</u> , 19 <u>66</u> , to <u>5/26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/26</u> , 19 <u>66</u> , and that death occurred at <u>9AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard H. Pollen</u>						22b. DATE SIGNED <u>5/26/66</u>			22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN</u>		
22d. ADDRESS <u>10511 Summit Ave. Kensington, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>28 May 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>						25a. REC'D BY REGISTRAR <u>JUN 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
03117									
07109									
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville					b. COUNTY Montgomery				
c. LENGTH OF STAY IN lb					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1300 Rockville Pike					d. STREET ADDRESS 1300 Rockville Pike				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last LEONARD B. DOGGETT, Sr.					4. DATE OF DEATH Month Day Year May 24 1966				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 10-26-1891				
9. AGE (In years last birthday) 74 yrs.					10. IF UNDER 1 YEAR Months Days				
11. IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired					10b. KIND OF BUSINESS OR INDUSTRY Auto Parking				
11. BIRTHPLACE (County & State, or foreign country) Virginia					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William Doggett					14. MOTHER'S MAIDEN NAME Cole				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. 578-05-7798/				
17. INFORMANT Marie R. Doggett, See Item No. 2					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 36 hours Acute lymphocytic leukemia 2 months DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 36 hours 2 months				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Hour e.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 5/10, 1966 to 5/24, 1966 that (I) (we) last saw the deceased alive on 5/24, 1966, and that death occurred at 1:28 PM, from the causes and on the date stated above.									
22a. SIGNATURE W. G. Hall M.D.					22b. DATE SIGNED 5/24/66				
22c. PHYSICIAN'S NAME (Type) Dr. W. G. Hall					22d. ADDRESS 615 West Montgomery Ave. Rockville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 5-27-1966				
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery					23d. LOCATION (City, town or county) (State) Silver Spring, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. DC.					25a. REC'D BY REGISTRAR JUN 2 1966				
25b. REGISTRAR'S SIGNATURE Charles Judge									

CERTIFICATE OF DEATH

07118

07110

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville (Rural)</u> c. LENGTH OF STAY IN b. <u>10 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NONE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville (Rural)</u> d. STREET ADDRESS <u>11900 Stony Creek Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Andrew</u> First <u>Leo</u> Middle <u>Donaldson</u> Last 4. DATE OF DEATH <u>May 24</u> 19 <u>66</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 6, 1896</u> 9. AGE (In years, last birthday) <u>70 yrs.</u> IF UNDER 1 YEAR Months <u>2</u> Days <u>18</u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> 11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John W. Donaldson</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Leach</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> 17. INFORMANT <u>Mrs. Rebecca Donaldson - Rockville, Md.</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of lung & metastases</u> 16-2X Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause last. <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> 20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> 19 <u> </u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> 19 <u> </u> to <u>May 24</u> 1966 that (we) last saw the deceased alive on <u>5/19</u> 1966 , and that death occurred at <u>5-09</u> P.M. , from the causes and on the date stated above			
22a. SIGNATURE <u>W. S. Murphy, M.D. for W. S. Murphy, M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>W. S. Hall, M.D. for W. S. Murphy, M.D.</u>		22b. DATE SIGNED <u>5/24/66</u> 22d. ADDRESS <u>615 WEST MONTGOMERY AVE. ROCKVILLE, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal/Burial</u> 23b. DATE THEREOF <u>May 27, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u> 23d. LOCATION (City, town or county) <u>Front Royal, VA.</u> (State) <u> </u>		24. REGISTRAR'S SIGNATURE <u>Robt. A. Humphrey, Bethesda, Md.</u> 25a. REC'D BY REGISTRAR <u>MAY 27 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

covering calls for Dr. Murphy's potential clearance with Medical Examiner 5/24/66 W. S. Hall, M.D.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07119

CERTIFICATE OF DEATH

07111

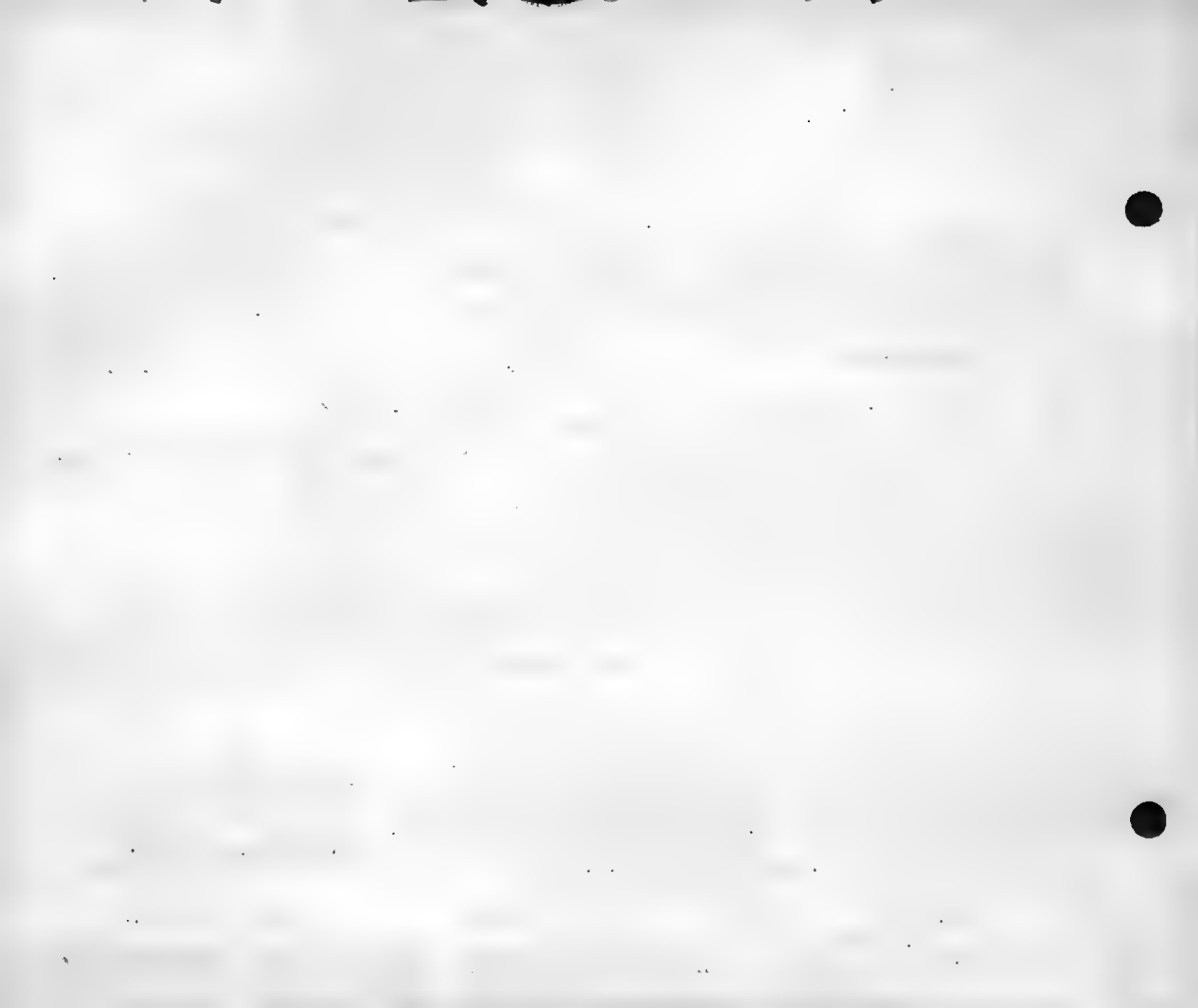
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll Hall Sanatorium</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>3700 Wendy Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>E.</u> Last <u>Amoran</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1966</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 1, 1878</u>		9. AGE (in years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H-Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Ezra T. Mahana</u>						14. MOTHER'S MAIDEN NAME <u>Harriet Nichols</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Robert O. Amoran</u> Address <u>Sene 2342</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>31X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) <u>Atherosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 yrs.</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> , 19 <u>66</u> to <u>4/29</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/29</u> , 19 <u>66</u> , and that death occurred at <u>1:45 AM</u> , from the causes and on the date stated above.															
22a. SIGNATURE <u>A.W. Smith</u>												22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>A.W. SMITH</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS <u>13018 GEORGIA AVE WHEATON, MD.</u>							
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/7/66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Mem. Park</u>				23d. LOCATION (City, town or county) (State) <u>Orlando Fla.</u>			
24. FUNERAL DIRECTOR <u>W.W. Chambers Inc</u>				ADDRESS <u>8655 Ga. Ave Silver Spring, Md</u>				25a. REC'D BY REGISTRAR <u>MAY 5 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN 1b <u>3 DAYS</u>		d. STREET ADDRESS <u>500 SOUTHWEST DRIVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAURICE WILSON DOWNS</u>		4. DATE OF DEATH Month Day Year <u>5 9 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-06</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GOVERNMENT PRINTING OFFICE - RETIRED</u>		9b. AGE (In years last birthday) <u>59</u> yrs.	
10a. BIRTHPLACE (County & State, or foreign country) <u>Seneca Maryland</u>		10b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
11. FATHER'S NAME <u>Maurice C. Downs</u>		12. MOTHER'S MAIDEN NAME <u>Sarah J. Miles</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		14. SOCIAL SECURITY NO. <u>NONE</u>	
15. INFIRMITY <u>YES</u>		16. ADDRESS <u>500 Southwest Drive Silver Spring, Maryland</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of left kidney with widespread metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>180X</u> DUE TO (c) <u>metastases</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>180X</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1966</u> to <u>5/9</u> , 1966, that (I) (we) last saw the deceased alive on <u>5/8</u> , 1966, and that death occurred at <u>8:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>G. Lennard Gold</u>		22b. DATE SIGNED <u>5/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold, M.D.</u>		22d. ADDRESS <u>8641 Colesville Road Silver Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11 May 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Monacacy Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Monacacy, Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>MAY 12 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
C7121					07113				
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			d. STREET ADDRESS 7007 24th Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Francis William Dudley		4. DATE OF DEATH Month Day Year 5 17 1966							
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/16/66	9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 13			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Wm. Dudley				14. MOTHER'S MAIDEN NAME Patricia Marian Moran					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Patricia Dudley, Address 7007-24th Ave Hyattsville, Md. mother					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7735 <u>Respiratory distress syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH Life Life	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5/16, 1966, to 5/17, 1966, that (I) we last saw the deceased alive on 5/17, 1966, and that death occurred at 5:29 P.M. from the causes and on the date stated above.									
22a. SIGNATURE J.F. McDaniel				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/18/66			
22c. PHYSICIAN'S NAME (Type) J.F. McDaniel				22d. ADDRESS 1000 LEBANON ST. SM. SP. MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 23, 1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR C. Glenister Warner E. Humphrey, Inc. Silver Spring, Md.				25a. REC'D BY REGISTRAR MAY 24 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner ~~along~~ ^{to} along with form PM3. Page 5 may be retained for your files.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07114

1. PLACE OF DEATH a COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE		Md.		b COUNTY		Mont. Co.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Bethesda					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		Suburban		d STREET ADDRESS		9000- Saunders Lane		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
Eleanor		Elizabeth		Dunlap		May		23		19 66	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		10. UNDER 1 YEAR Months Days Hours Min	
female		white				9/23/02		63 yrs		8 0 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Booker Housewife		woodworker		Maryland		U.S. A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Richard Saunders		Nellie Bean									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		214-32-9370 Unknown		Edward T. Dunlap		Husband/same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE 0700 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)		- Drug intoxication Overdose of acetaminophen		INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1B) Accidentally took overdose of drug for her arthritis		20c. TIME OF INJURY Month, Day, Year 5:30 a.m. 5/23 19 66		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home		20f. (City or town) (County) (State) Bethesda, Cabin John Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 5/24/66		23a. BURLINGAME (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
John G. Ball		M.D.		Burial		May 26, 1966		Parklawn Cemetery		Rockville Maryland	
24. FUNERAL DIRECTOR Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REG. STRAR MAY 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rockville

c. LENGTH OF STAY IN

7 years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

304 Baltimore Road

3 NAME OF DECEASED
(Type or print)

First

Middle

Last

Maggie

Virginia

Duval

5. SEX

F

W

6. COLOR OR RACE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

July 1, 1878

4 DATE OF DEATH

Month

Day

Year

May

29

19 66

9 AGE (In years last birthday)

87 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Home

11 BIRTHPLACE (Country & State or foreign country)

Md.

USA

13. FATHER'S NAME

Gideon Draper Briggs

14. MOTHER'S MAIDEN NAME

Ida Virginia Sparrow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

no

17 INFORMANT

Mrs. Aimee B. Harper Same as 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

443x

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Cerebral hemorrhage

Hypertensive cardiovascular disease

INTERVAL BETWEEN ONSET OF DEATH

2 days

7 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

none

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from April 19 59 to May 29 1966 that (I) last saw the deceased alive on May 29 1966, and that death occurred from the causes and on the date stated above.

22a. SIGNATURE

W. A. Linthicum, M.D.

ATTENDING PHYS. ☒

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

5/29/66

22c. PHYSICIAN'S NAME (Type)

W. A. Linthicum

22d. ADDRESS

1105 Washington St. Rockville, Md.

23b. BURIAL, CREMATION REMOVAL (Specify)

Burial

23c. DATE THEREOF

June 1, 1966

23d. NAME OF CEMETERY OR CREMATORY

Galesville

23e. LOCATION (City, town or county)

Galesville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE

Francis H. Barber

ADDRESS

Laytonsville, Md.

25a. REC'D BY REGISTRAR

JUN 3 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

1. The first part of the report

is a general introduction

to the subject

of the study

and the scope

of the investigation

is a description

of the methods

used in the study

and the results

of the study

are presented

in the

conclusion of the report

and the

scope

of the investigation

is

the

1. The first part of the report

is a general introduction

to

the subject of the study

CERTIFICATE OF DEATH

07124

07116

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton, Md. c. LENGTH OF STAY IN 1b 11 MONTHS		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton, Maryland 2 (P. CODE) 20906	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		d. STREET ADDRESS 3802 Elby Court, Wheaton, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Amelia GLADYS Edelstein		4. DATE OF DEATH Month Day Year May 11 1966	
5. SEX F	6. COLOR OR RACE Caus.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22 1901
9. AGE (In years (Birthdays) yrs) 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundal County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Philip Aaron		14. MOTHER'S MAIDEN NAME Alice Fogelman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-22-1150	
17. INFORMANT MARTIN EDWARDS		Address AS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, RIGHT LOWER LOBE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HOMIPLERIA, LEFT (c) CEREBRAL THROMBOSIS			INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 5 DAYS 5 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/29 , 19 63 , to 5/11 , 19 66 , that (I) (we) last saw the deceased alive on 5/11 , 19 66 , and that death occurred at 4:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE James A. Roberts		22b. DATE SIGNED MAY 11, 1966	
22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS		22d. ADDRESS 8907 GEO. AVE. SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 13, 1966	23c. NAME OF CEMETERY OR CREMATORY Beth Tfiloh	23d. LOCATION (City or Town) (County) (State) Woodlawn, Maryland
24. FUNERAL DIRECTOR Sol. Levinson & Bros, Inc. 6010 Reisterstown Rd		25a. REC'D BY REGISTRAR MAY 16 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10225 Kensington Pky</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>el</u> Last <u>James Edwards</u>	4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1966</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24, 1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED ENLISTED USA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	
11. BIRTHPLACE (State or foreign country) <u>TEXAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>KENNETH MALCOLM EDWARDS (DECEASED)</u>		14. MOTHER'S MAIDEN NAME <u>DAISY VIRGINIA DODSON (DECEASED)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>464-01-9242</u>	
17. INFORMANT <u>PARKWAY, KENSINGTON, MD. APT. 708</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>5/9/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		M.D. <u>Bethesda</u>	
7936 Old Georgetown Road, Maryland		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12 May 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY, ARLINGTON, VIRGINIA</u>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>8434 George Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
MAY 12 1966			



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

07126

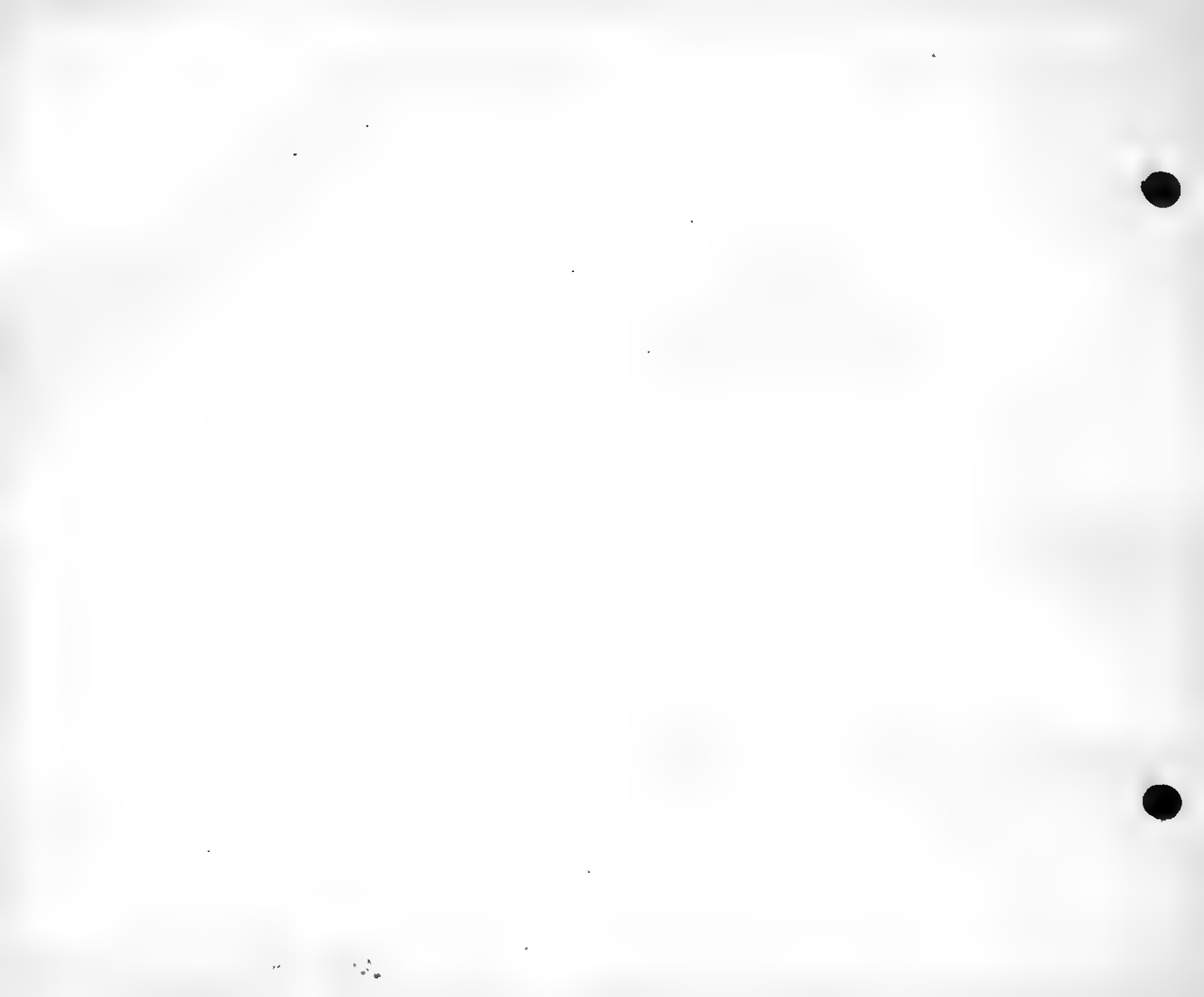
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07118

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY (In days) 7 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANITARIUM HOSPITAL		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS ROUTE #2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) BENJAMIN AUGUST ELLIN, SR. First Middle Last 4 DATE OF DEATH MAY 6 Month Day Year 19 66		5 SEX MALE 6 COLOR OR RACE WHITE 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH 2-14-98 9 AGE (In years last birthday) 88 yrs FUNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED 10b. KIND OF BUSINESS OR INDUSTRY TRUCK FARMER 11 BIRTHPLACE (State or foreign country) D.C. 12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME BENJAMIN ELLIN 14 MOTHER'S MAIDEN NAME FLORENCE WILSON	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO 16 SOCIAL SECURITY NO PATIENT'S CHART 17 INFORMANT PATIENT'S CHART Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. 9040 IMMEDIATE CAUSE (a) Pulmonary embolism, massive, bilateral. DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Deceased fell at home fracturing left hip.			
20c. TIME OF INJURY Month, Day, Year 12:30 pm 4/30 19 66 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Silver Spring Montg Md			
21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Belden R. Reap M.D. EXAMINER'S NAME (Type) BELDEN R. REAP M.D. 22. DATE SIGNED May 7, 1966		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF May 9-1966 23c. NAME OF CEMETERY OR CREMATORY St. Luke's 23d. LOCATION (City or town) (County) (State) Fairbank Montg Md		24 FUNERAL DIRECTOR Arthur Walters ADDRESS 454 Gough St 25a. REC'D BY REGISTRAR Charles Judge DATE MAY 10 1966 25b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and it must be returned within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please register the death with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CLEARANCE BY CORNER DR. ROBERT

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07127

07119

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING, MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1908 AUGUST DRIVE</u>		d. STREET ADDRESS <u>1908 AUGUST DRIVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALLENE</u> Middle <u>M.</u> Last <u>ELLIS</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>19</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/25/1913</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Clerk-Typist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>(U.S.) Washington DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James Martin</u>		14. MOTHER'S MAIDEN NAME <u>Alice Warwick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>577-28-5381</u>	
17. INFORMANT <u>James W. Martin - 1908 August Drive SSMD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA, ACUTE</u> <u>2551</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>HYPOTHYROIDISM AND MYXEDEMA</u> DUE TO (c) <u>ANEMIA, ACUTE DUE TO GI BLEEDING</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 MINUTES</u> <u>1 Year</u> <u>3 WEEKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HEPATIC INSUFFICIENCY AND MALNUTRITION</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>10/13</u> 19 <u>58</u> to <u>5/19</u> 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>5/19</u> 19 <u>66</u> , and that death occurred at <u>10:15</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>James A. Roberts</u> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED <u>5/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>		22d. ADDRESS <u>8907 GEO. AVE. SILVER SPRING, MD.</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-23-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Sons, Inc.</u>		25. REC'D BY REGISTRAR <u>MAY 25 1966</u>	
25a. ADDRESS <u>5130 Wisc. Ave. N.W. Wash. DC.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

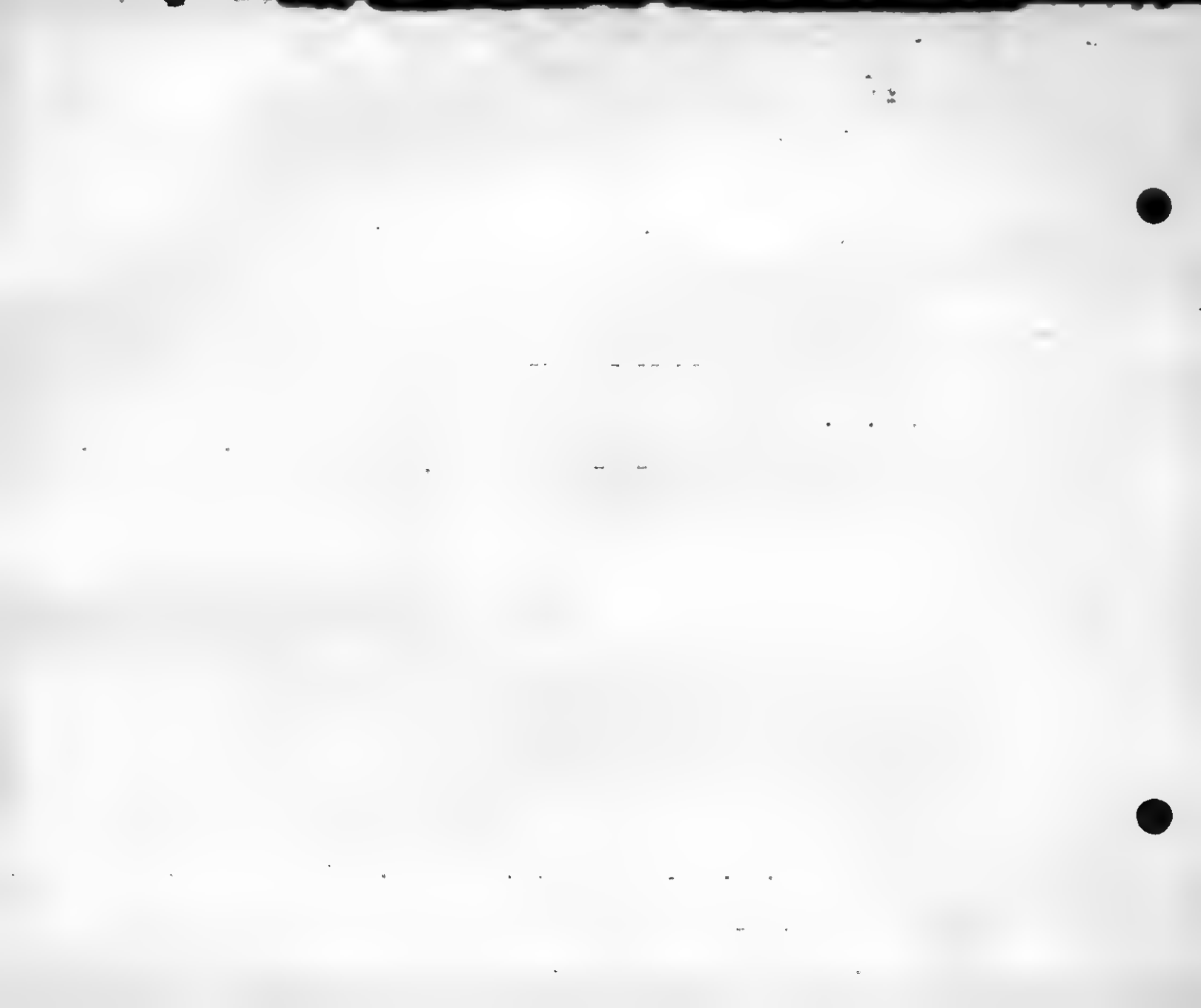
CERTIFICATE OF DEATH

07120

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONT.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN Tb 15 Mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) POTOMAC VALLEY NURSING Home		d. STREET ADDRESS 101 EVANS STREET	
3 NAME OF DECEASED (Type or print) KATHERINE O. ENGLAND		4. DATE OF DEATH Month MAY Day 21 Year 1966	
5 SEX F	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 3, 1889 77 yrs.
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State for foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME L. I. G. Owings		14. MOTHER'S MAIDEN NAME Ella Linthicum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-28-1639	
17. INFORMANT Son		18. ADDRESS 6 W. Argyle St. Rockville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 603 X Uremia DUE TO (b) Surgical loss of kidney - nephrectomy DUE TO (c) in other kidney		INTERVAL BETWEEN ONSET AND DEATH 4 years 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1955 , 19 5/19 19 66 , to 5/21 , 19 66 , that (I) (we) last saw the deceased alive on 5/19 19 66 , and that death occurred at 2:07 PM , from causes and on the date stated above			
22a. SIGNATURE W. G. Hall M.D.		22b. DATE SIGNED 5/21/66	
22c. PHYSICIAN'S NAME (Type) W. G. Hall M.D.		22d. ADDRESS 615 W. Montgomery Ave., Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-23-66	23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery	23d. LOCATION (City or town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY Bethesda, Maryland		25a. REC'D BY REGISTRAR MAY 25 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

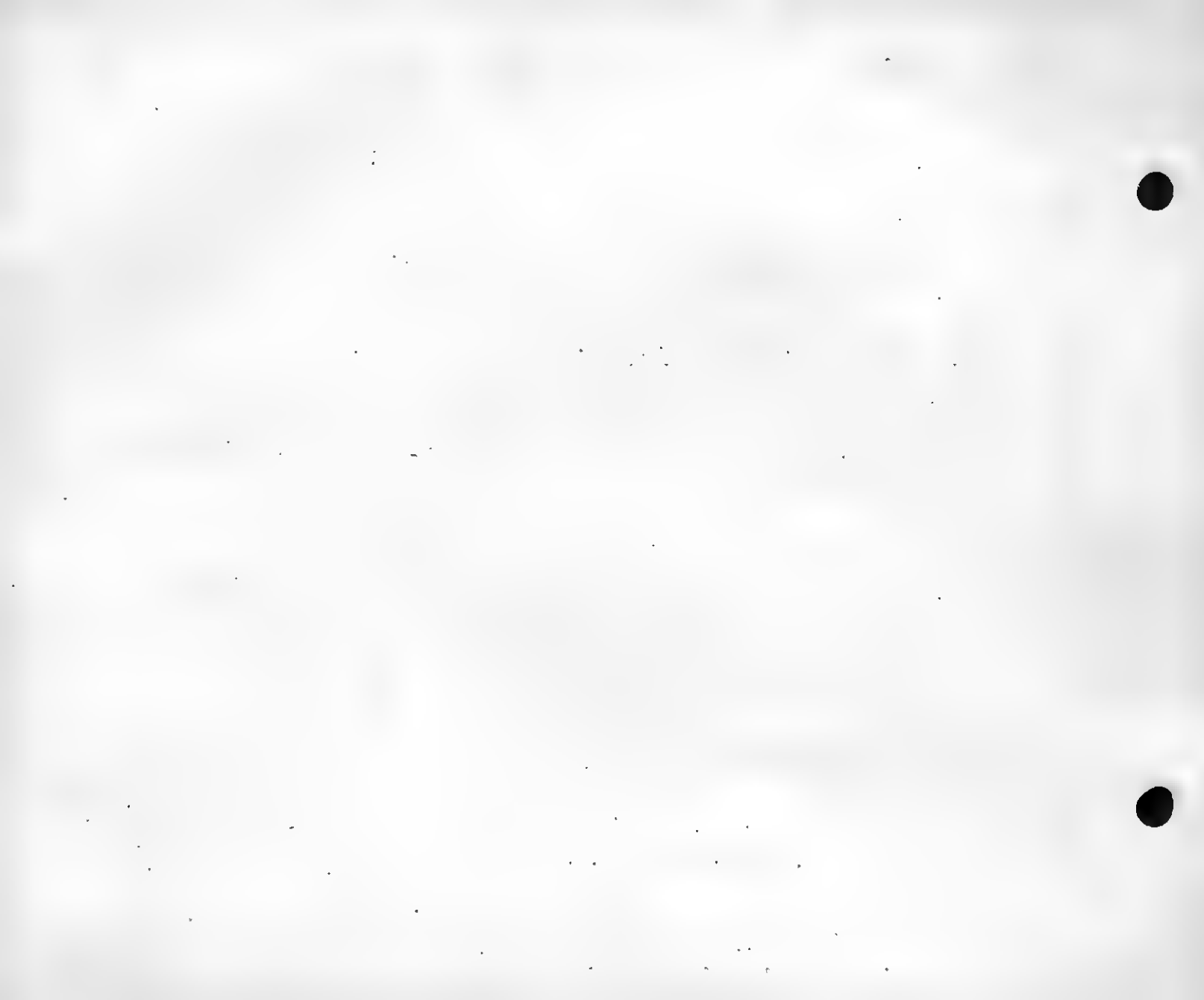
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07122											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING, Md.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSP.</u>						d. STREET ADDRESS <u>8505 SPRINGVALE Rd.</u>					
3. NAME OF DECEASED (Type or print) First <u>DOROTHY</u> Middle <u>C</u> Last <u>ERICKSEN</u>						4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/7/89</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Computer Operator US S. Office</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Post</u>		11. BIRTHPLACE (County & State, or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hubert Walleette</u>						14. MOTHER'S MAIDEN NAME <u>Denise Boudreaux</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>						16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Dolores J. Malaszewski</u> Address <u>3317 Clay Street Wheaton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Pulmonary Embolus</u> <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombophlebitis</u> DUE TO (c) <u>Disseminated Adenocarcinoma of Breast</u>										INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>days</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>65</u> , to <u>5/4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/4</u> 19 <u>66</u> , and that death occurred at <u>10PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>G. Lennard Gold</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/5/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold, M.D.</u>						22d. ADDRESS <u>8641 Colesville Rd. Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9 May 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>					
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u> Address <u>8434 Georgia Avenue Silver Spring, Md.</u>						25a. REC'D BY REGISTRAR <u>MAY 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 and 6 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

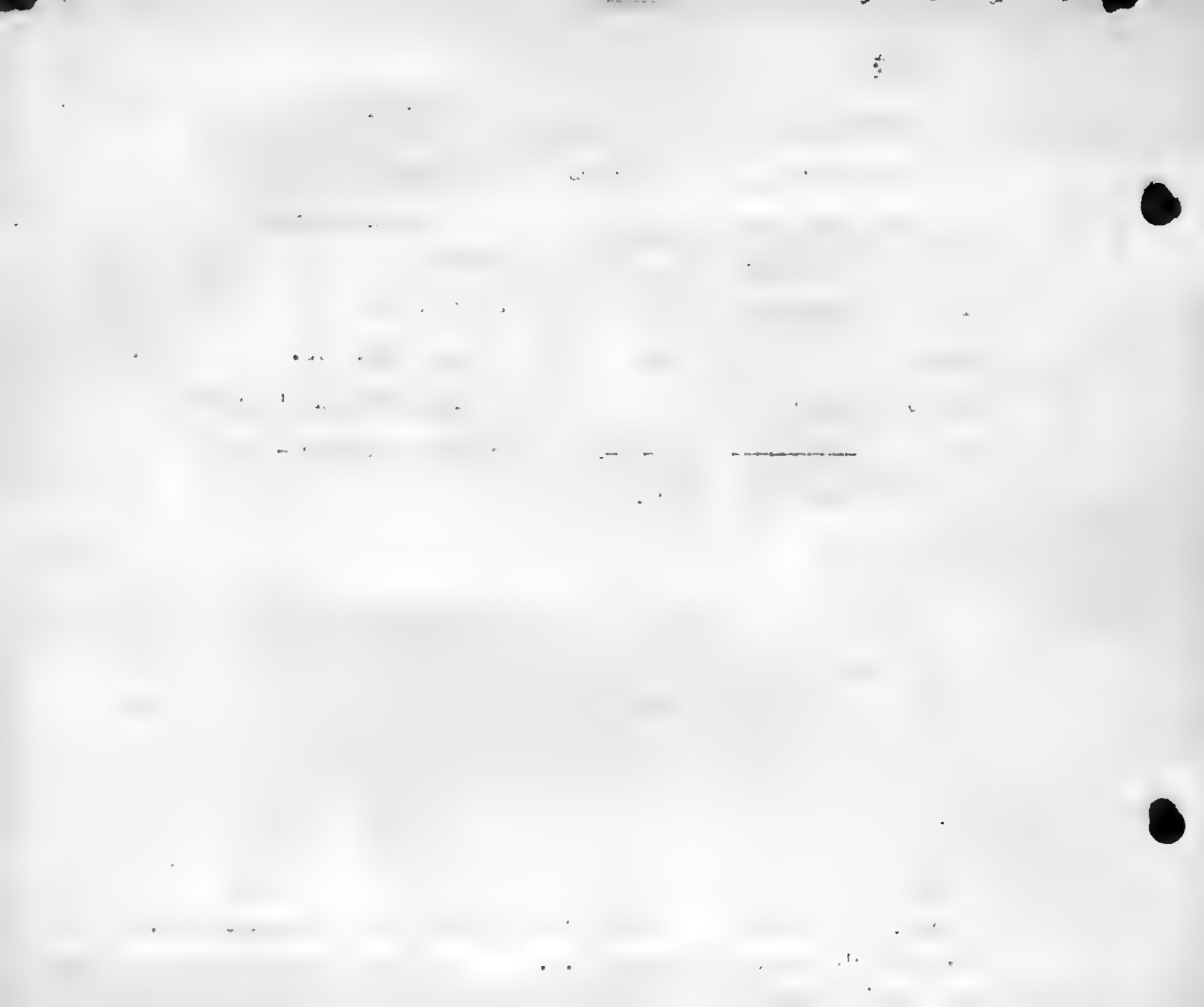
VR A1SME
5M 1/63

Items 18&21 Film G379		MARYLAND STATE DEPARTMENT OF HEALTH	
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
C7130		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
Items 8,9 Film G379		07122	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GARRETT PARK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>4900 Strathmore Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Leila</u> Middle <u>Eslick</u> Last <u>Eslick</u>		4. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1890</u> <u>9/13/194</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>472-24-1848</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left coronary artery thrombosis;</u> <u>7:01</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>Arteriosclerotic heart disease.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 8, 1966</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>5/12/66</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillside</u>		22d. LOCATION (City, town, or county) (State) <u>Platteville, Wisconsin</u>	
23. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		24a. REC'D BY REGISTRAR <u>May 10 1966</u>	
ADDRESS <u>1331 Rockville Pike</u> <u>Rockville, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
C71131					C7123				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> c. LENGTH OF STAY IN 1b <u>Years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3809 Club Drive</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. STREET ADDRESS <u>3809 Club Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>NMI</u> Last <u>FISCHER</u>			4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>66</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 1, 1889</u> 9. AGE (In years last birthday) <u>76</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Deerbrook, Wis.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John B. Fischer</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Von O'Stransky</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>220-44-1936</u>		17. INFORMANT <u>Marguerite Fischer - Same as # 2</u> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prostatic carcinoma, prostate</u> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intestinal carcinoma</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								INTERVAL BETWEEN ONSET AND DEATH <u>7 1/2 years</u> <u>3 months</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept., 1962</u> , to <u>May 26, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 26, 1966</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Frank R. Shea</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 26, 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>FRANK R. SHEA</u>					22d. ADDRESS <u>4100 - 22nd St NE Wash DC 20018</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>5/31/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>		
24. FUNERAL DIRECTOR <u>Jos. Gawler's Sons, Washington, D.C.</u> ADDRESS					25a. REC'D BY REGISTRAR <u>JUN 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>		

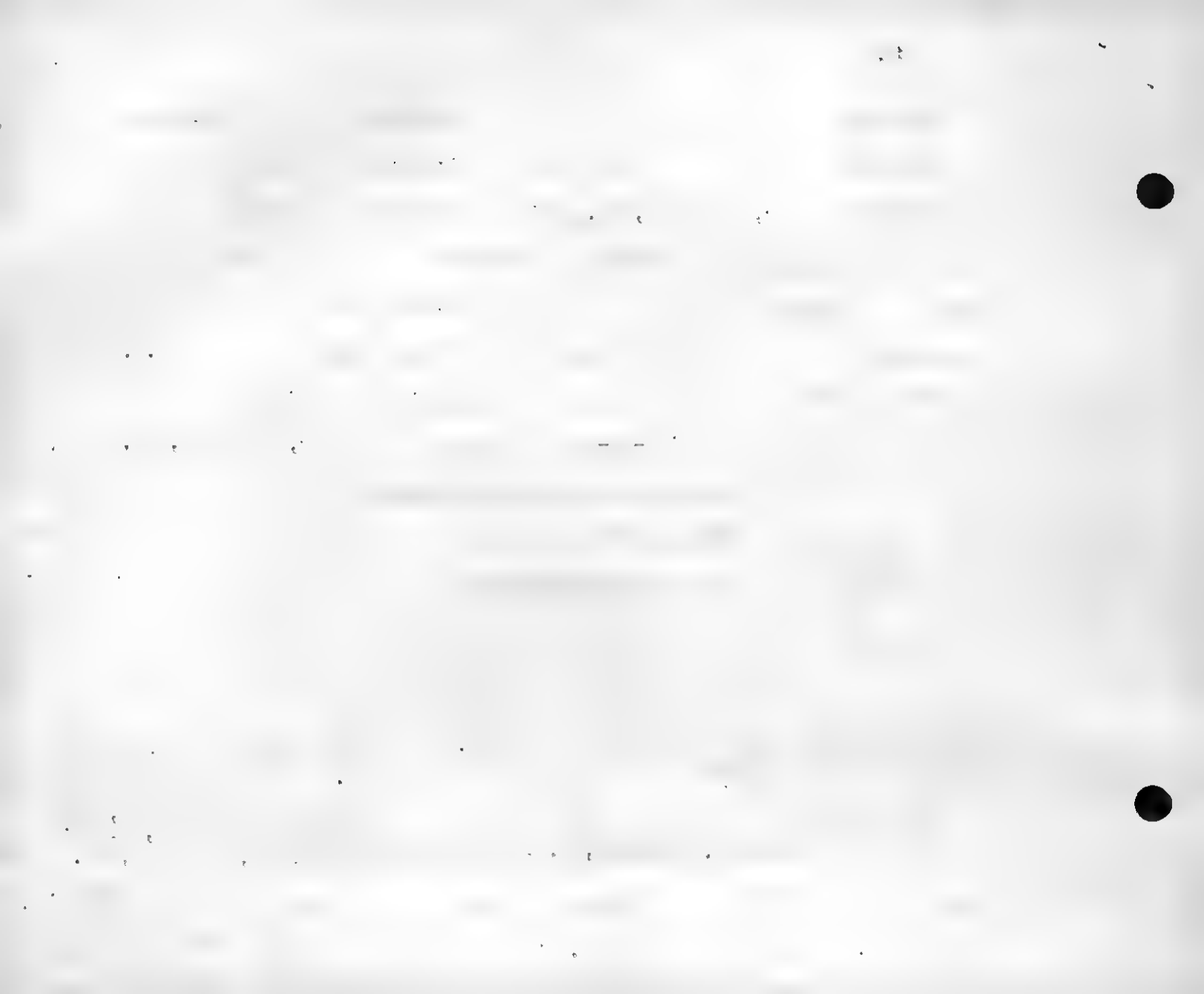


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN ID 43 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 502 East 38th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) John William Forshaw			4. DATE OF DEATH May 3 1966		5. SEX Male			6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 20 February 1908			9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 2 Days 13 Hours Min. 		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Albert Forshaw					14. MOTHER'S MAIDEN NAME Priscilla Malone						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 173-09-6339		17. INFORMANT The Medical Record The Clinical Center, Bethesda, Md. 20014						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intraoperative Aortic Dissection 410X DUE TO (b) Mitral Stenosis DUE TO (c) Rheumatic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 											
INTERVAL BETWEEN ONSET AND DEATH 5 days 25 years 50 years											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 21, 1966 , to May 3, 1966 , that 10 (we) last saw the deceased alive on May 3, 1966 , and that death occurred at 7:45 M., from the causes and on the date stated above.											
22a. SIGNATURE Douglas M. Behrendt					22b. DATE SIGNED May 4, 1966						
22c. PHYSICIAN'S NAME (Type) Douglas M. Behrendt, M.D.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/6/1966		23c. NAME OF CEMETERY OR CREMATORY Mound Cemetery		23d. LOCATION (City, town or county) (State) Williamsport, Lycoming Co. Penna.				
24. FUNERAL DIRECTOR Robert A. Pumphrey					25a. REC'D BY REGISTRAR MAY 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

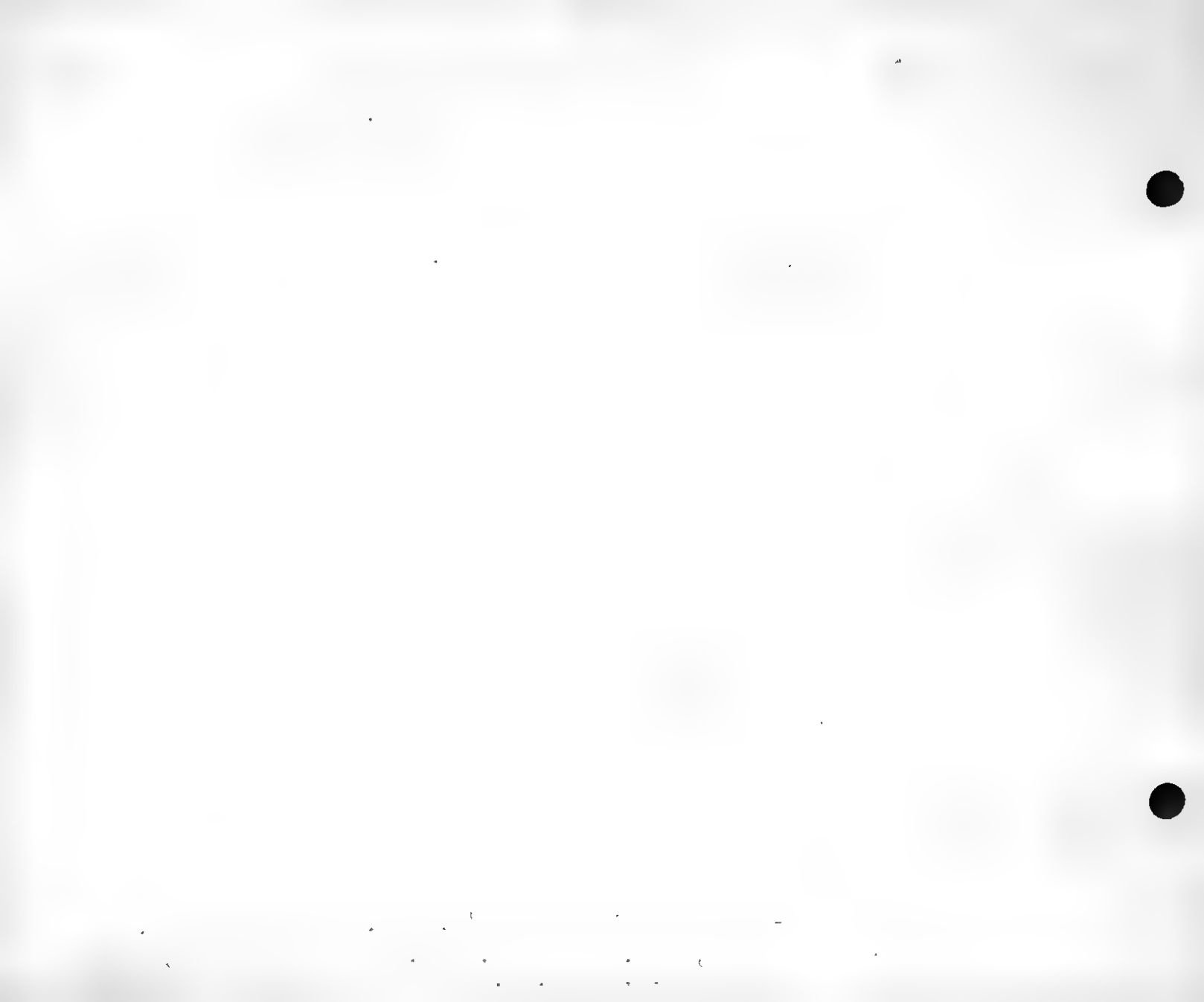
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or is designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MD. b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda.		c LENGTH OF STAY IN 1b Bethesda.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5601 Newington.		e STREET ADDRESS 5601 Newington Rd.	
3 NAME OF DECEASED (Type or print) William Henry Fortlines		4 DATE OF DEATH Month May Day 11 Year 1966	
5 SEX M.	6 COLOR OR RACE W.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-13-1916
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		9 AGE (In years last birthday) 49 yrs	11 BIRTHPLACE (State or foreign country) Alabama
13 FATHER'S NAME William Henry Fortlines Sr.		12 CITIZEN OF WHAT COUNTRY U.S.A.	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) Yes WWII		16 SOCIAL SECURITY NO - -	
17 INFORMANT Wife - Mary Ellen.		Address	
18 CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Barbiturate Poisoning 9702 DUE TO (b) over dose of - Nebutal DUE TO (c) -			INTERVAL BETWEEN ONSET AND DEATH 72 hr.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Took over dose of Nebutal + Sed. Amital	
20c TIME OF INJURY Month, Day, Year 12:30 p.m. 5/11 1966		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home
20f (City or town) Bethesda, Mont. Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5/11/66	
		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	5-16-1966	Arlington Nat'l. Cem.	Arlington, Va.
24. FUNERAL DIRECTOR Joseph Lawler's Sons, Inc.		25a REC'D BY REGISTRAR MAY 13 1966	
ADDRESS 5130 Wisc. Ave. N.W. Wash. DC.		25b REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY COUNTY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM HOSPITAL</u>					d. STREET ADDRESS <u>2703 Arundel Road</u>					
3. NAME OF DECEASED (Type or print) First <u>VIOLA</u> Middle <u>NMN</u> Last <u>FRANK</u>					4. DATE OF DEATH Month <u>MAY</u> Day <u>27</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/20/96</u>		9. AGE (In years last birthday) <u>69</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>		
13. FATHER'S NAME <u>Unobtainable</u>					14. MOTHER'S MAIDEN NAME <u>EMMA E. JOHNSON</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Albert K. Frank</u> <u>HUSBAND</u> Same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia associated</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>with septicemia and fractured lumbar vertebra</u> DUE TO (c) <u>-</u>									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Belden R. Reap</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>5/31/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md</u>	
24. FUNERAL DIRECTOR <u>The S.H. Hines Company-Washington, D. C.</u>					25a. REC'D BY REGISTRAR <u>JUN 2 1966</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07127

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cherry Chase	
c. LENGTH OF STAY IN 1b 4 days		d. STREET ADDRESS 121 Hesketh Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anne Last TALIMAN Fraser		4. DATE OF DEATH Month May Day 24 Year 1966	
5. SEX Fe.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/26/57
9. AGE (In years last birthday) 8 yrs.		10. FUNERAL 1 YEAR IF UNDER 24 HRS. Months 10 Days 28 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Child	
11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Donald M. Fraser		14. MOTHER'S MAIDEN NAME Arvonne Skelton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 000000000000	
17. INFORMANT Donald M. Fraser, same item #2 (father)		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration + Contusion of Brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Injuries from colliding with Auto DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Struck by Auto when Crossing Street -	
20c. TIME OF INJURY Month, Day, Year 3 p.m. 5/20 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street -		20f. (City or town) Cherry Chase Mont. (County) Md. (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		22. DATE SIGNED 5/24/66	
EXAMINER'S NAME (Type) JOHN G. BALL		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5/25/66	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) (State) Prince Geo. Cp., Md.	
24. FUNERAL DIRECTOR TYSON WHEELER		25a. REC'D BY REGISTRAR MAY 26 1966	
ADDRESS 1331 Rockville Pike Rockville, Maryland		25b. REGISTRAR'S SIGNATURE J Charles Judge	

C7136

CERTIFICATE OF DEATH

07128

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>9495 McArthur Blvd.</u>	
3 NAME OF DECEASED (Type or print) <u>William H. Frazier</u>		4 DATE OF DEATH Month <u>5</u> Day <u>26</u> Year <u>1966</u>	
5 SEX <u>M.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-2-93</u>
9 AGE (In years last birthday) <u>73</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Frazier</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Clark</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Son - Wilson - Same</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular diseases</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u> </u> Month, Day, Year <u>19</u> p.m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>October 10, 1965</u> to <u>May 26, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 25, 1966</u> , and that death occurred at <u>1:15 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Donald Q. Ekman</u>		22b. DATE SIGNED <u>5/26/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald Q. Ekman</u>		22d. ADDRESS <u>4720 Ch. ch. Dr. Chevy Chase, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/28/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sperryville</u>	23d. LOCATION (City or town) (County) (State) <u>Sperryville, Va.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Rockville, Maryland</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>MAY 31 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07129

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item 18. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and must be retained within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY **MONTGOMERY** b. CITY OR TOWN, if outside corporate limits (write RURAL and give nearest town) **OLNEY** c. LENGTH OF STAY IN b **1 day** d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **MONTGOMERY GENERAL HOSPITAL**

2. USUAL RESIDENCE (Where deceased lived, if institution; Resident or transient) e. STATE **MARYLAND** f. COUNTY **MONTGOMERY** g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **SILVER SPRING** h. STREET ADDRESS **GOOD HOPE RD.** i. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) **EVANS** **GAITHER** 4. DATE OF DEATH **MAY 19 1966** 5. SEX **Male** 6. COLOR OR RACE **Colored** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **6/10/03** 9. AGE (In years last birthday) **62** yrs. IF UNDER 1 YEAR Months Days Hours M n. IF UNDER 24 HRS. Hours M n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **landscaper** 10b. KIND OF BUSINESS OR INDUSTRY **MARYLAND** 11. BIRTHPLACE (State or foreign country) **MARYLAND** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **LLOYD GAITHER** 14. MOTHER'S MAIDEN NAME **FLORENCE KING**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) **NO** 16. SOCIAL SECURITY NO **HOSPITAL RECORDS - MGH** 17. INFORMANT **Olney, Md.** Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Acute Cerebro-vascular Hemorrhage; Essential Hypertension**
Conditions, if any, which gave rise to immediate cause (b) **331X**
(a), stating the underlying cause last. (c) **DUE TO**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **INTERVAL BETWEEN ONSET AND DEATH**

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Belden R. Reap, M.D.** CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED **May 20, 1966**
EXAMINER'S NAME (Type) **BELDEN R. REAP, M.D.** DEPUTY MEDICAL EXAMINER ☒ Address (Street, city, town, or county) **Wheaton, Md.**

22a. BURIAL, CREMATION, or REMOVAL (Specify) **BURIAL** 22b. DATE THEREOF **5/23/66** 22c. NAME OF CEMETERY OR CREMATORY **Brown Chapel** 22d. LOCATION (City, town, or country) (State) **Dayton Md**

23. FUNERAL DIRECTOR **Robert R. Snowden** ADDRESS **Rockville, Md.** 24a. REC'D BY REGISTRAR **MAY 25 1966** 24b. REGISTRAR'S SIGNATURE **Charles Judge**

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

C7138

C7130

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN lb Washington Sanitarium Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale d. STREET ADDRESS 6109 43rd Street e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) HARRY M. GARBER Sr.		4 DATE OF DEATH Month May Day 27 Year 19 66	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 4, 1895
9 AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U.S. P.O.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (County & State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Garber		14. MOTHER'S MAIDEN NAME Elizabeth Whorey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO 217 42 4211	
17. INFORMANT Mary W. Garber Same as #2 (wife)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 4201 IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) 54 DUE TO (c) 7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Fibrosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/28 , 19 66 , to 5/27 , 19 66 , that (I) (we) last saw the deceased alive on 5/27 , 19 66 and that death occurred at 3/28 M, from causes and on the date stated above.			
22a. SIGNATURE Hebert Wachsler		22b. DATE SIGNED 3/28	
22c. PHYSICIAN'S NAME (Type) Hebert Wachsler		22d. ADDRESS 120 Ego St N W Wash DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/31/66	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor, P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR JUN 3 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
C7139 CERTIFICATE OF DEATH C7131											
1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
c. LENGTH OF STAY IN 1b <u>7 days</u>						d. STREET ADDRESS <u>812-Kenbrook Drive</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>											
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Gardner</u> Last <u>Gardner</u>						4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-6-98</u>		9. AGE (in years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTROLLER - RETIRED</u>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>DANIEL SCHATZ-812 KENBROOK DR. S.S. MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Thrombosis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Ruptured Myocardial</u>											
DUE TO (c) <u>Acute Myocardial Infarction</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 19, 1966</u> to <u>May 24, 1966</u> that (I) (we) last saw the deceased alive on <u>24 May 1966</u> and that death occurred at <u>11</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Walter E. Goode</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER E. GOODE MD.</u>						22d. ADDRESS <u>2390 GLENMONT CIR. WHITEHORN MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-27-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>TEMPLE BETH EL CEM. WHITEBORO - N.Y.</u>				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR <u>B. DANZANSKY & SONS WASHINGTON DC.</u>						25a. REC'D BY REGISTRAR <u>MAY 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>12 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>					d. STREET ADDRESS <u>11509 Soward Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joan</u> Middle <u>Frances</u> Last <u>Geldner</u>					4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 22, 1962</u>		9. AGE (In years last birthday) <u>3 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Franklin Geldner</u>					14. MOTHER'S MAIDEN NAME <u>Mildred Hogan</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John F. Geldner</u> Address <u>11509 Soward Drive Wheaton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic CARCINOMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> , 19 <u>66</u> , to <u>5/30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/30</u> , 19 <u>66</u> , and that death occurred at <u>11:30</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Marvin N. Trebb RD</u>								22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN N. TREBB RD</u>					22d. ADDRESS <u>2401 Blue Ridge Ave Silver Spring, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 3, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>					25a. REC'D BY REGISTRAR <u>JUN 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>WICHT COUNTY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>IN</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d STREET ADDRESS <u>8514 GREENWOOD AVE</u>	
3 NAME OF DECEASED (Type or print) <u>INFANT MALE GERMAN</u>		4 DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>1966</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>Cauc</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5/7/66</u>
9 AGE (In years last birthday) yrs		10 IF UNDER 1 YEAR Months <u>16</u> Days <u>3</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>DONALD L. GERMAN</u>		14 MOTHER'S MAIDEN NAME <u>ROBERTA L. GARNER (GERMAN)</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>—</u>	
17 INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fetal anoxia, secondary to severe</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>maternal toxemia of pregnancy.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Neap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. NEAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>May 8, 1966</u>		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>5-9-66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Gate 1 Heaven Cemetery</u>		23d LOCATION (City or town) (County) (State) <u>Spring Md</u>	
24. FUNERAL DIRECTOR <u>Francis J. Reelin</u>		ADDRESS <u>3821-1474 St. W. Wash. DC</u>	
25a REC'D BY REGISTRAR <u>Charles Judge</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 10 1966</u>			

CERTIFICATE OF DEATH

07134

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN 1b <u>11 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6812 Laurel N.W.-Wash.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Emory Myron Girdner</u> 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>8-17-80</u> 9. AGE (In years last birthday) <u>86</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School TEACHER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Missouri</u> 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William J. Girdner</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NO</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Shirah</u> 17. INFORMANT <u>HOSPITAL RECORDS</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain tumor</u> DUE TO (b) <u>Monocytic leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>1965</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>65</u> to <u>May</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>27 May 1965</u> , and that death occurred at <u>12 PM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>W. E. F. J.</u> 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation 5-23-66</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u> ADDRESS <u>Washington, D.C.</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>JUN 2 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07143											
07135											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONT.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> 15-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>12907-MORAY RD.</u>						d. STREET ADDRESS <u>12907-MORAY RD.</u>					
3. NAME OF DECEASED (Type or print) <u>LEWIS</u> First Middle Last <u>GOLDBERG</u>						4. DATE OF DEATH Month <u>MAY</u> Day <u>5</u> Year <u>1966</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-27-80</u>		9. AGE (In years last birthday) <u>86</u> yrs.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ICE- MERCHANT</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO.					
17. INFORMANT <u>Bernard Goldberg-2907 Moray Rd.</u>						Address <u>Wheaton, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY ARTERY HEART DISEASE</u> 4201 DUE TO (b) <u>INTERVAL BETWEEN ONSET AND DEATH 14 YEARS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS, CEREBRAL ARTERIO-SCLEROSIS</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/27, 1963</u> to <u>5/5, 1966</u> , that (I) (we) last saw the deceased alive on <u>5/2, 1966</u> , and that death occurred at <u>12A</u> M., from the causes and on the date stated above.											
22a. SIGNATURE <u>David Goldenberg</u>						22b. DATE SIGNED <u>5/5/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>DAVID GOLDENBERG</u>						22d. ADDRESS <u>10620 GEORGINA SILVER SPRING MARYLAND</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/6/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Ridgewood, New York</u>			
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY</u>						25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
25a. REC'D BY REGISTRAR <u>3501 14th St. N.W., D.C.</u>						DATE <u>MAY 9 1966</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

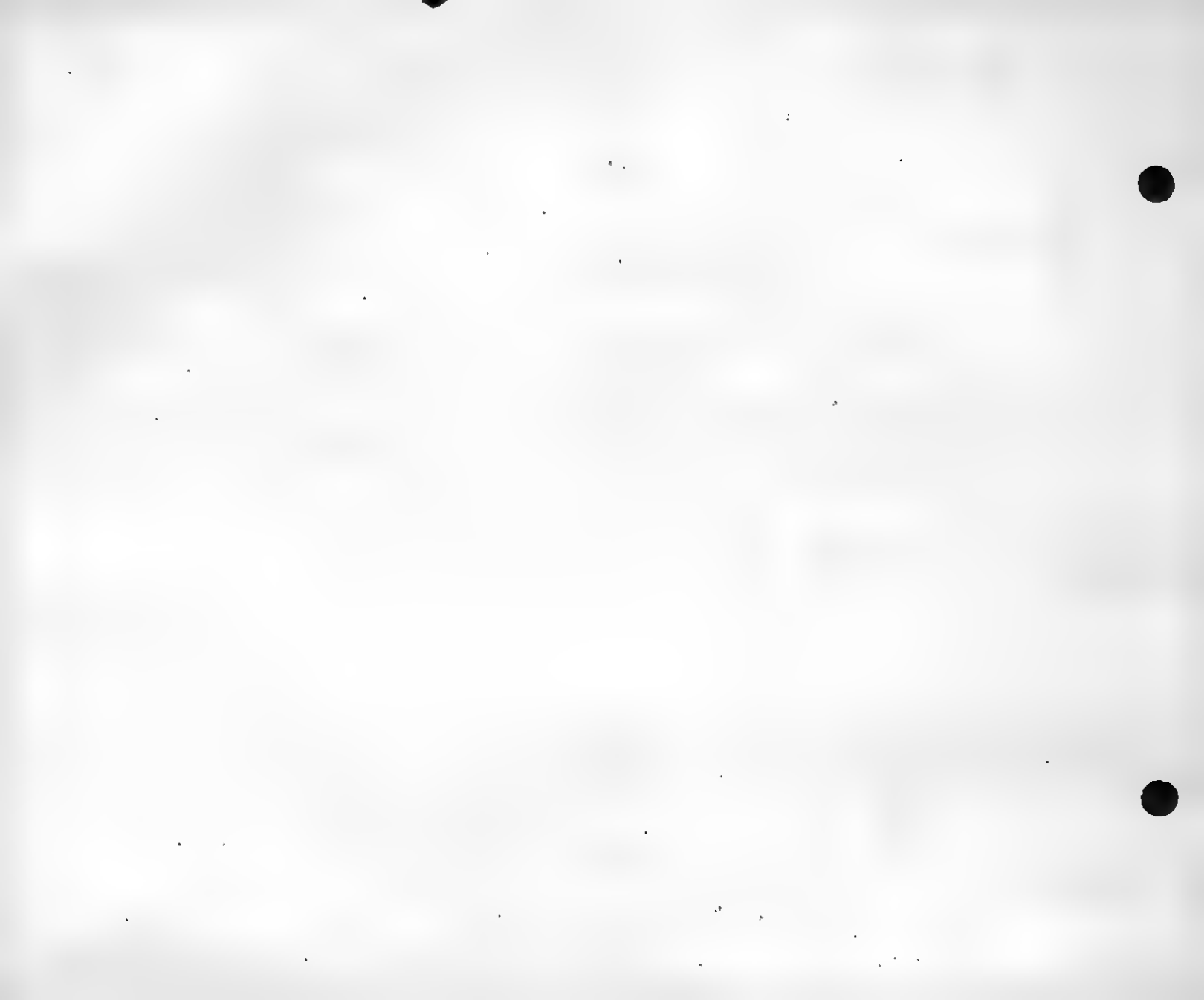
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 day - 16 hrs. - 45 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>24 Manor Circle Apt. 108</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Isidore</u> Middle <u>Meyer</u> Last <u>Goldstein</u>		4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1894</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Merchandise Mgr.</u>		9b. KIND OF BUSINESS OR INDUSTRY	
10a. BIRTHPLACE (County & State, or foreign country) <u>Roumania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Moses Goldstein</u>		14. MOTHER'S MAIDEN NAME <u>Eva Cohen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>7600 Carroll Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive cerebral infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>due to thrombosis</u> DUE TO (c) <u>12 hr.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>May 14, 1966</u> , to <u>May 16, 1966</u> , that (1) (we) last saw the deceased alive on <u>May 15, 1966</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Gene U. Cohen M.D.</u>		22b. DATE SIGNED <u>May 16, '66</u>	
22c. PHYSICIAN'S NAME (Type) <u>GENE U. COHEN, M.D.</u>		22d. ADDRESS <u>1106 SPRING ST. N.W. WASH. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-17-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN - FALLS CHURCH VA</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY & SONS - WASH. D.C.</u>		25a. REC'D BY REGISTRAR <u>MAY 19 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b (Nineteen) <u>19 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> d. STREET ADDRESS <u>403 Thayer Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Emily Deloach</u> First Middle Last 4. DATE OF DEATH <u>May 4 1966</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1-18-99</u> 9. AGE (in years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.S.W.F.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>St. Louis, Missouri</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Virgil Deloach</u> 14. MOTHER'S MAIDEN NAME <u>Estelle Schwimmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMANT <u>Daughter - Mrs. Joan Buckalew</u> Address <u>Same (2)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphatic Leukemia</u> 2040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , to <u>May 4, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 4</u> 19 <u>66</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above. 22a. SIGNATURE <u>Philip E. Jones</u> 22c. PHYSICIAN'S NAME (Type) <u>Philip E. Jones, MD</u> 22b. DATE SIGNED <u>5-5-66</u> 22d. ADDRESS <u>800 Pershing Drive Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>May 9, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> 23d. LOCATION (city, town or county) (State) <u>Arlington, Virginia</u>		24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u> 25a. REC'D BY REGISTRAR <u>MAY 9 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07146

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07138

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived f institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9617 Dilston Rd.</u>		d. STREET ADDRESS <u>2705 13th St. N.E., Apt 42</u>	
3 NAME OF DECEASED (Type or print) First <u>Eddie</u> Middle <u>Lee</u> Last <u>Green</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>M</u>	6 COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28, 1940</u>
9. AGE (In years last birthday) <u>25</u> yrs		IF UNDER 1 YEAR Months <u>25</u> Days <u>25</u> Hours <u>25</u> Min. <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>	
11. BIRTHPLACE (State or foreign country) <u>Buena Vista, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Leroy Green</u>		14. MOTHER'S MAIDEN NAME <u>Laura Marie Hicks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Donnie L. Everette</u>		Address <u>5509 1st N.W. Washington, D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Guns shot wound, right temple, with intracranial hemorrhage, self-inflicted.</u> DUE TO (b) <u>temple, with intracranial hemorrhage, self-inflicted.</u> DUE TO (c) <u>hemorrhage, self-inflicted.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NA. DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II or item 18) <u>Deceased shot self in head</u>	
20c. TIME OF INJURY Month Day, Year <u>May 5-7 1966</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Home</u>	20f. (City or town) <u>Silver Spring</u> (County) <u>Montgomery</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Peap</u> M.D.		22. DATE SIGNED <u>May 7, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. PEAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <u>Robert L. Snowden</u> Address <u>246 N. Washington St. Rockville, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>TRANSIT</u>	23b. DATE THEREOF <u>May 10, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State) <u>Camden, Arkansas</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>MAY 11 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

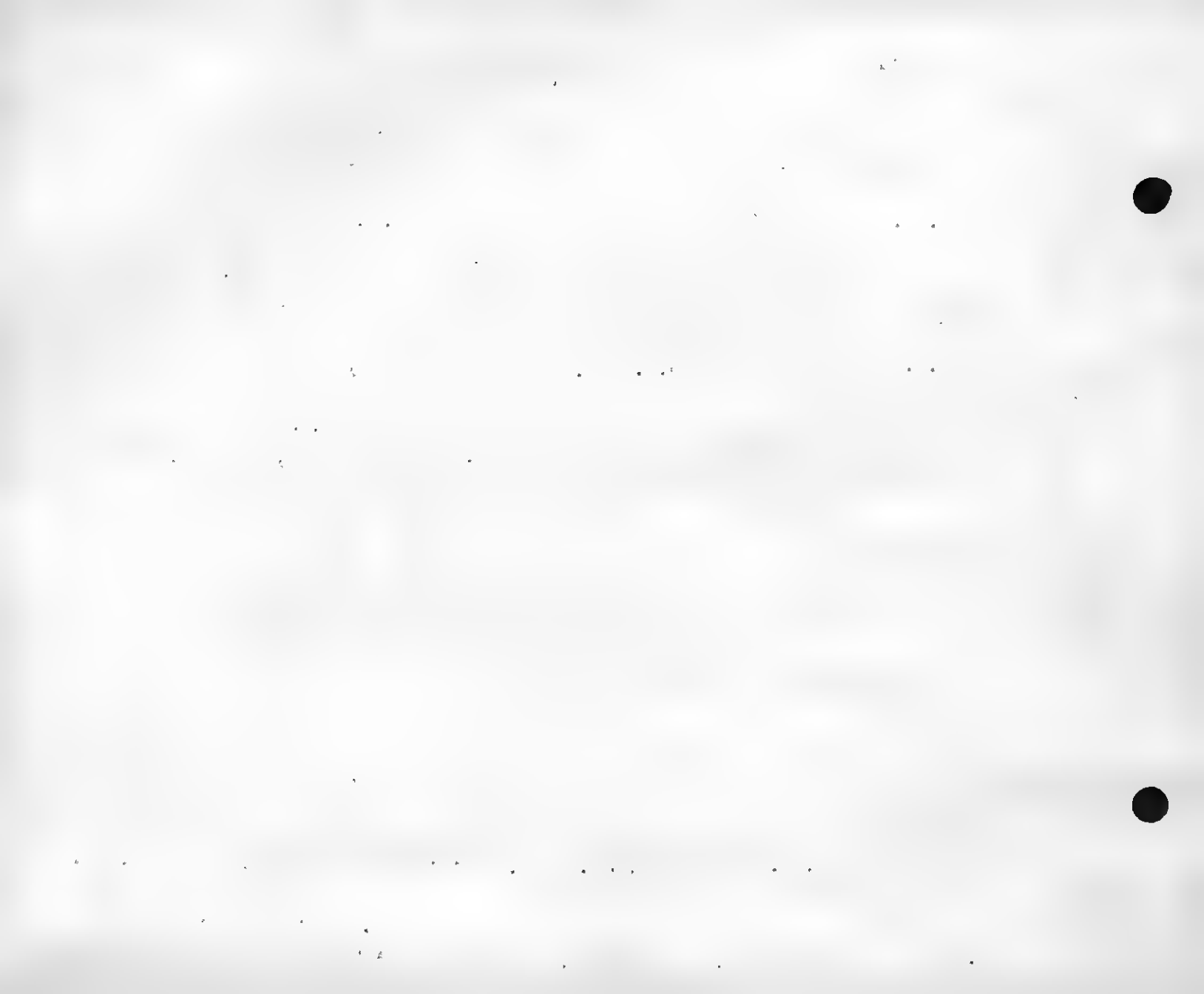
07147

07139

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c LENGTH OF STAY IN 1b 32 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U. S. Naval Hospital		d. STREET ADDRESS Box 135, Route #2	
3 NAME OF DECEASED (Type or print) First "W" Middle "P" Last GUNTER		4 DATE OF DEATH Month May Day 6 Year 19 66	
5 SEX Female	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH December 6, 1916
9 AGE (In years last birthday) yrs 49		IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy (Retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.	
11 BIRTHPLACE (County & State, or foreign country) Enterprise, Alabama		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Carl Gunter		14. MOTHER'S MAIDEN NAME Tura Thompson	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1939-1959		16. SOCIAL SECURITY NO 427 185 807	
17 INFORMANT Mrs. Lillian Gunter, Box 135, Route 2/		18. ADDRESS Hollywood Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cirrhosis of the liver with hepatic coma 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory street office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from April 13 , 19 66 , to May 6 , 19 66 , that (1) (we) lost saw the deceased alive on May 6 , 19 66 , and that death occurred at 2304 M , from causes on and on the date stated above			
22a. SIGNATURE G. T. Strickland Jr. M.D.		22b. DATE SIGNED May 6, 1966	
22c. PHYSICIAN'S NAME (Type) G. T. Strickland, Jr. M. D.		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/11/1966	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24 FUNERAL DIRECTOR Robinson Funeral Home, Leonardtown, Maryland		25a. REC'D BY REGISTRAR DATE MAY 10 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

C7148

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C7140

1 PLACE OF DEATH a COUNTY <i>Montgomery</i> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <i>Maryland</i> b COUNTY <i>Montgomery</i> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Poolesville</i>	
3 NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Earl</i> Last <i>Hahn</i>		4 DATE OF DEATH Month <i>May</i> Day <i>14</i> Year <i>1966</i>	
5 SEX <i>male</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>4/15/06</i>
9 AGE (In years, last birthday) <i>60</i>		10 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - Carpenter</i>	
11 BIRTHPLACE (State or foreign country) <i>Frederick, Maryland</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13 FATHER'S NAME <i>Charles Samuel Hahn</i>		14 MOTHER'S MAIDEN NAME <i>Elizabeth Ziegler</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16 SOCIAL SECURITY NO. <i>214-10-5410</i>	
17 INFORMANT <i>Evelyn Hahn (wife)</i>		Address <i>add. same</i>	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage Massive.</i> 4221 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <i>Cerebral Arteriosclerosis -</i> DUE TO (c) <i>Cardio-Vascular Disease -</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 days.</i> <i>Years</i> <i>Years.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John S. Ball</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>5/14/66</i>	
		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <i>5-17-66</i>	23c NAME OF CEMETERY OR CREMATORY <i>Union Chapel Cemetery Frederick, Md.</i>	23d LOCATION (City or town) (County) (State)
24 FUNERAL DIRECTOR <i>Charles C. Fathner</i>		25a REC'D BY REGISTRAR <i>Charles Judge</i>	
		25b REGISTRAR'S SIGNATURE	
		DATE <i>MAY 17 1966</i>	



FOR STATE
HEALTH DEPT.

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VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07143

07141

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>48 hrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laytonsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>12-2nd St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Lee</u> Last <u>Hahn</u>				4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 22, 1911</u>	
9. AGE (in years last birthday) <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Businessman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert George Hahn</u>				14. MOTHER'S MAIDEN NAME <u>Linda Esch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-18-9302</u>		17. INFORMANT <u>Gertrud Hahn/ same as above.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> OUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>				22. DATE SIGNED <u>5/27/66</u>			
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>				M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-30-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Herman Church Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bethesda, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>				25a. REC'D BY REGISTRAR <u>MAY 31 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07150

07142

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
c. LENGTH OF STAY IN b. <u>10 years</u>				d. STREET ADDRESS <u>3419 Plyers Mill Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Beda Charlotta Halberg</u>		First Middle Last		4. DATE OF DEATH <u>May 24 1966</u>		Month Day Year	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 8, 1880</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Sweden</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Esther Arms</u>				Address <u>3419 Plyers Mill Rd. Kensington, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Atherosclerosis</u> (a), stating the underlying cause last. (c) <u>1 day</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 year</u>						INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 8, 1966</u> to <u>May 4, 1966</u> that (I) (we) last saw the deceased alive on <u>May 24, 1966</u> and that death occurred at <u>8:30 A.M.</u> from the cause and on the date stated above.							
22a. SIGNATURE <u>John J. Curry</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/24/66</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>10620 Georgia Ave S.E. Wash</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>26 May 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Vinehill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Plymouth, Mass.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 26 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

CERTIFICATE OF DEATH

07143

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>23 days</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4704 W. FRANKFORT DR.</u>	
3. NAME OF DECEASED (Type or print) <u>ARLETTA G HALLOCK</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-9-11</u>
9. AGE (In years last birthday) <u>54</u> yrs		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUA. OCCUPAT. ON (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Kingsien, Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MICHAEL GRAY</u>		14. MOTHER'S MAIDEN NAME <u>FANNY CLARK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>199-12-3487</u>	
17. INFORMANT <u>Husband</u>		Address <u>Ab.ve</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1550 GENERALIZED METASTASIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) <u>OBSTRUCTIVE JAUNDICE</u> DUE TO (c) <u>CHOLANGIOCARCINOMA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u> <u>3 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 12, 1966</u> to <u>MAY 25, 1966</u> , that (I) (we) lost saw the deceased alive on <u>MAY 24, 1966</u> , and that death occurred at <u>4:10 A.M.</u> , from causes and on the date stated above			
22a. SIGNATURE <u>William Frank</u>		22b. DATE SIGNED <u>MAY 25, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM FRANK, M.D.</u>		22d. ADDRESS <u>11125 ROCKVILLE PIKE, ROCKVILLE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/28/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Shavertown, Pa.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 26 1966</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07152

CERTIFICATE OF DEATH

07144

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c LENGTH OF STAY IN 1b 4 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d STREET ADDRESS #1 Judi Drive Box 25	
3 NAME OF DECEASED (Type or print) First Adolph Middle August Last HAPPEL		4 DATE OF DEATH Month May Day 21 Year 66	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 21, 1925
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b KIND OF BUSINESS OR INDUSTRY RETIRED	
11 BIRTHPLACE (County & State, or foreign country) Bronx, N. Y.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1942-1965		16. SOCIAL SECURITY NO 096-16-4760	
17. INFORMANT Bryans Rd.		Address Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4200 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from May 17 , 19 66 , to May 21 , 19 66 , that (X) (we) last saw the deceased alive on May 21 , 19 66 and that death occurred at 800PM , from causes and on the date stated above.			
22a. SIGNATURE Robert L. Piscatelli		22b. DATE SIGNED 23 May 1966	
22c. PHYSICIAN'S NAME (Type) Robert L. Piscatelli		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF May 25, 1966	
23c NAME OF CEMETERY OR CREMATORY Trinity Memorial Gardens		23d LOCATION (City or Town) (County) (State) Waldorf, Maryland	
24. FUNERAL DIRECTOR Hunt's Funeral Home, Waldorf, Maryland		25a. REC'D BY REGISTRAR MAY 27 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07155

07145

1. PLACE OF DEATH a. COUNTY MONTGOMERY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital			d. STREET ADDRESS 11522 Charlton Dr.		
3. NAME OF DECEASED (Type or print) First Middle Last IVETHA W. HARRIS			4. DATE OF DEATH Month Day Year 5 22 1966		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 15, 1915		9. AGE (in years last birthday) 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ROMANIA	
13. FATHER'S NAME MORRIS			14. MOTHER'S MAIDEN NAME SAIDIE KRUPNICK		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW II		17. INFORMANT PAUL S. HARAB	
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c) A.S.H.D.		INTERVAL BETWEEN ONSET AND DEATH 2 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1954 19 to 5:22 , 19 66 , that (I) (we) last saw the deceased alive on 5 22 19 66 and that death occurred at 12 PM from the causes and on the date stated above.					
22a. SIGNATURE Bernard Katzen			22b. DATE SIGNED 5-22-66		
22c. PHYSICIAN'S NAME (Type) BERNARD KATZEN M.D.			22d. ADDRESS 2645 N. N. S. E.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF May 24, 1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town or county) (State) Arlington, Va.		24. FUNERAL DIRECTOR B. Danzansky & Sons		25a. REC'D BY REGISTRAR MAY 26 1966	
		25b. REGISTRAR'S SIGNATURE g Charles Judge			

- Closed with Dr. Holden Sharp Medical Examiner - May

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07156

07146

1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 4506 FURMAN Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON SANITARIUM & HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle HARTSON Last HARTSON				4. DATE OF DEATH Month MAY Day 13 Year 1966			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-3-80	
9. AGE (In years last birthday) 86 yrs		IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min. 86		IF UNDER 24 HRS. Months 86 Days 86 Hours 86 Min. 86			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles B. Ewing				14. MOTHER'S MAIDEN NAME Harriet Chaney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 1221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 1221							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 11, 1966 , to May 13, 1966 , that (I) (we) last saw the deceased alive on May 12, 1966 , and that death occurred at 9:20 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Gene U. Cohen M.D.				22b. DATE SIGNED May 13, 1966		22c. PHYSICIAN'S NAME (Type) GENE U. COHEN	
22d. ADDRESS 1106 Spring Street, Silver Spring MD				22e. REC'D BY REGISTRAR MAY 17 1966		22f. REGISTRAR'S SIGNATURE J. Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 18, 1966		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Prince Georges Co. Md.	
24. FUNERAL DIRECTOR J. Arthur Walters				25. ADDRESS 254 Carroll NW 4			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>Item 20 Film G378 6/29/66</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>													
07155 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DICKERSON</u>						07147 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Narrows</u> d. STREET ADDRESS <u>Box 248</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MARK</u> First <u>RODNEY</u> Middle <u>HAVENS</u> Last 4. DATE OF DEATH <u>May 8</u> 19 <u>66</u>						5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>3-30-45</u> 9. AGE (In years, if UNDER 1 YEAR, if UNDER 24 HRS last birthday) <u>21</u> yrs. <u>1</u> Months <u>8</u> Days <u></u> Hours <u></u> Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lineman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>P.B. UTIL. (Elec)</u> 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>						13. FATHER'S NAME <u>Mark A. Havens</u> 14. MOTHER'S MAIDEN NAME <u>Myrtle Ferguson</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>280-56-8658</u> 17. INFORMANT <u>Hospital Records</u> Address													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INJURIES Multiple, SEVERE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fall from ELECTRICAL TOWER (100ft)</u> (c)												INTERVAL BETWEEN ONSET & DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased fell from electrical tower 100 ft. high.</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7:20</u> p.m. <u>5/8</u> 19 <u>66</u>						20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Field</u>		20f. (City or town) (County) (State) <u>Dickerson Montg. Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Belden R. Reap M.D.</u> EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>May 8, 1966</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 5-8-66</u>						23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Narrows, Virginia</u>			
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>						ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAY 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay in execution, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

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VR AISM (5)
5M 1/65

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Washington, D.C.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>R. Cropley</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wide Water. Cro Canal.</u>		d. STREET ADDRESS <u>6217 30th St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>David</u> Last <u>Hawkins</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>N.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/27/1944</u>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bakers. Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baking.</u>	9. AGE (in years last birthday) <u>21</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Washington.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kenith. Mc Hawkins</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy McKeever</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Father.</u>		Address <u>SAME AS #2 ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia -</u> <u>18</u> DUE TO <u>Drowning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>water swimming suddenly sank -</u>	
20c. TIME OF INJURY Month, Day, Year <u>8:30 p.m. 5/18 1966</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>canal -</u>	20f. (City or town) (County) (State) <u>Cropley Mont. MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>5/20/66</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		Address (Street, city, town, or county) <u>—</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5/23/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEM.</u>	23d. LOCATION (City, town or county) (State) <u>WASHINGTON, D.C.</u>
24. FUNERAL DIRECTOR <u>JOS. GAULER'S SONS, INC. WASH. D.C.</u>		25a. REC'D BY REGISTRAR <u>MAY 25 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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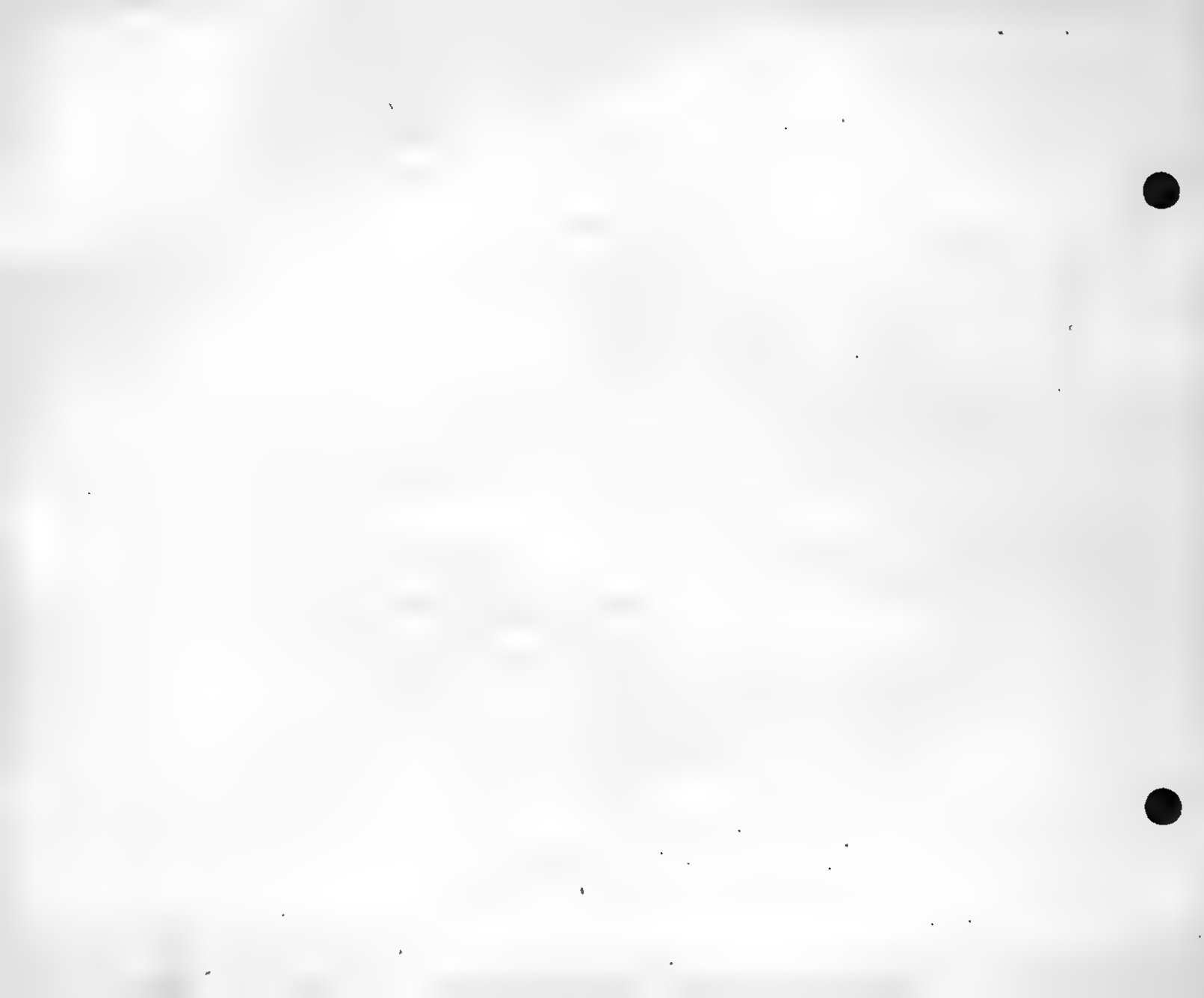
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u>	
c. LENGTH OF STAY IN 1b <u>D.O.A</u>		d. STREET ADDRESS <u>208 Cedar Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LARRY</u> Middle <u>HAYES</u> Last <u>HAYES</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 17 - 1966</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <u>3 mos</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>	
13. FATHER'S NAME <u>James. Hayes.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		14. MOTHER'S MAIDEN NAME <u>Frances Munroe</u>	
16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT Address <u>Father #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia -</u> <u>471X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>5/18/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		M.D. <u>7936 Old Georgetown Road</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/21/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	23d. LOCATION (City, town or county) (State) <u>Gaithersburg Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Pik</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>MAY 23 1966</u>	



CERTIFICATE OF DEATH

07158

07150

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEETHESDA</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>5053 BRADLEY BLVD.</u>	
3 NAME OF DECEASED (Type or print) <u>JAMES E. HEFFERMAN</u>		4 DATE OF DEATH <u>MAY 6 1966</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-86</u>
9 AGE (In years, last birthday) <u>79</u> yrs		10 UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Country & State, or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>093-14-9213A</u>	
17. INFORMANT <u>Hosp Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pharyngeal Obstruction</u> (c) <u>CARCINOMA of the Tongue</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/20</u> , 19 <u>66</u> to <u>5/5</u> , 19 <u>66</u> that (I) (we) las saw the deceased alive on <u>5/5</u> , 19 <u>66</u> and that death occurred at <u>6:30</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Robert A. Barnett</u>		22b. DATE SIGNED <u>5/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT A. BARNETT M.D.</u>		22d. ADDRESS <u>809 Viers Mill Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/13/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pottersfield</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville Md.</u>
24. FUNERAL DIRECTOR <u>Sydney Wheeler 1331 Rockville Pike Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>DA</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please prepare carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN ID <u>5 mths</u>		d. STREET ADDRESS <u>13604 Aqua Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>W.</u> Last <u>Herbert</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 28 1880</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia PENN</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Bensted</u>		14. MOTHER'S MAIDEN NAME <u>NA AVAILABLE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. MARY H. HOUCK.</u>		Address <u>13604 AQUA LANE ROCKVILLE MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Coronary arteriosclerosis</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 Hr.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-9</u> , 19 <u>66</u> , to <u>5-7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-3</u> 19 <u>66</u> , and that death occurred at <u>5:10</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Bury / SN Jones</u>		22b. DATE SIGNED <u>5-7-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>SN Jones</u>		22d. ADDRESS <u>809 Veirs Mill Rd Rockville</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>MAY 10-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HARLEIGH CEMETERY</u>	23d. LOCATION (City, town or county) (State) <u>Callingswood. New Jersey</u>
24. FUNERAL DIRECTOR <u>Northwest Funeral Home Washington, D.C. 20012</u>		25. REC'D BY REGISTRAR / 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

07160

CERTIFICATE OF DEATH

Reg. Dist. No.

07152

1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY MONTG			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10516 ST. PAUL STREET				d. STREET ADDRESS 10516 St Paul Street			
3. NAME OF DECEASED (Type or print) WILLIAM (NONE) HESS				4. DATE OF DEATH May 8 1966			
5. SEX M		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 9, 1884	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT (RET)				10b. KIND OF BUSINESS OR INDUSTRY DRY GOODS			
11. BIRTHPLACE (State or foreign country) GERMANY				12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME HEINRICH HESS				14. MOTHER'S MAIDEN NAME ROSA LEVY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO 338-12-4654			
17. INFORMANT William W. Hess				18. ADDRESS 128 20th Street, ROCKVILLE, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhages 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis - generalized DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Apr. 29 1966 to May 8 1966 that I last saw the deceased alive on May 2 1966 and that death occurred at Kensington, Md. from the causes and on the date stated above ADDRESS (Street, city or town, state) 3720 Farragut Avenue DATE SIGNED May 8, 1966							
ACTUAL SIGNATURE Robert T. Thibadeau				PHYSICIAN'S NAME (Type) Robert T. Thibadeau			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 5-9-66			
22c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON CEM.				22d. LOCATION (City, town, or county) (State) HATTSVILLE MD			
23. FUNERAL DIRECTOR'S SIGNATURE Wedberg Funeral Home				24a. REC'D BY REGISTRAR MAY 10 1966			
ADDRESS 4217 9th St. NW				24b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

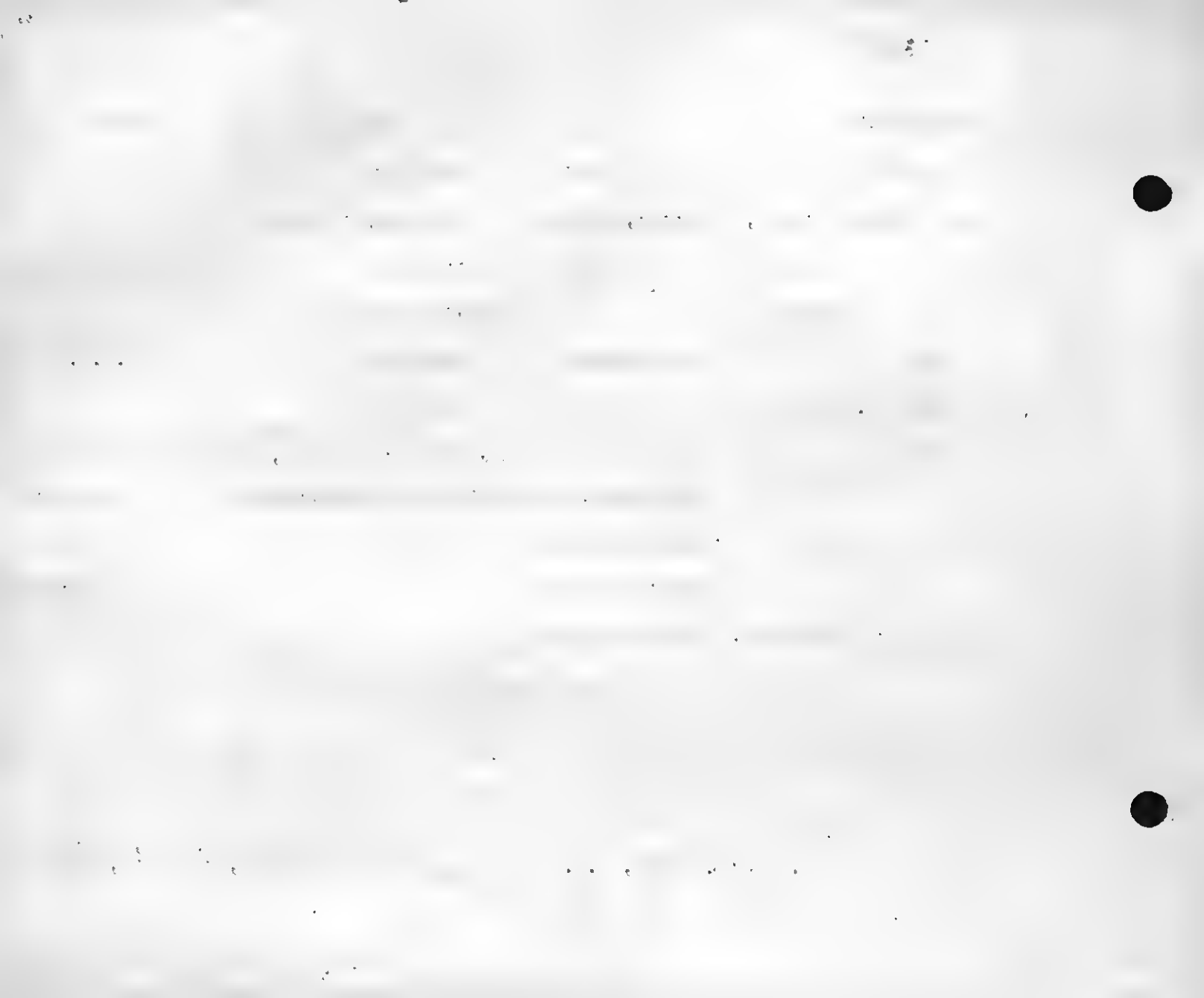
1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>9 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>	
3 NAME OF DECEASED (Type or print) <i>Clemond W. Hodgson</i>		d. STREET ADDRESS <i>3512 Nimitz Rd.</i>	
5. SEX <i>M</i> 6. COLOR OR RACE <i>W</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <i>5-24-66</i> Month <i>5</i> Day <i>24</i> Year <i>1966</i>	
8. DATE OF BIRTH <i>12-28-09</i> 9. AGE (In years last birthday) <i>56</i> yrs.		IF UNDER 1 YEAR Months <i>4</i> Days <i>26</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Relief Supervisor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>D.C. Transit</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Raymond Hodgson</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>1942-1945</i>		16. SOCIAL SECURITY NO. <i>139-03-8419</i>	
17. INFORMANT <i>Ruth - wife - same</i> Address <i></i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchogenic carcinoma, left lung with/widespread metastasis</i> DUE TO (b) <i></i> DUE TO (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>21</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> of work <i></i> of work <i></i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1963</i> , 19 <i>5-24</i> , 1966, that (I) (we) lost saw the deceased alive on <i>5-24</i> 1966, and that death occurred at <i>7:25 A.M.</i> from causes and on the date stated above			
22a. SIGNATURE <i>Morris Perry</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5-24-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Morris Perry</i>		22d. ADDRESS <i>11602 Georgia Ave., Silver Spring, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/27/66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>		23d. LOCATION (City or Town) (County) (State) <i>Arlington, Virginia</i>	
24. FUNERAL DIRECTOR <i>TYSON WHEELER</i>		25a. REC'D BY REGISTRAR <i>MAY 26 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 37 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air d. STREET ADDRESS Southampton Farm e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) John Brian Holden			4. DATE OF DEATH Month May Day 5 Year 1966			5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 14 July 1945			9. AGE (In years last birthday) 20 yrs.			10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 24 HRS <input type="checkbox"/> Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk						10b. KIND OF BUSINESS OR INDUSTRY Government			11. BIRTHPLACE (County & State, or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.						13. FATHER'S NAME Gwynne L. Holden					
14. MOTHER'S MAIDEN NAME Jean Todd						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					
16. SOCIAL SECURITY NO. Not available						17. INFORMANT The Medical Records Address The Clinical Center, Bethesda, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral and spinal cord hemorrhage 201x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Thrombocytopenia DUE TO (c) Hodgkins disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic hepatitis; diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 42 hours 1 year 1 1/2 years											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 29 March, 1966 to 5 May, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5 May, 1966 , and that death occurred at 3:45 P M, from the causes and on the date stated above.											
22a. SIGNATURE H. Thomas Foley M.D.											
22b. DATE SIGNED 6 May 1966											
22c. PHYSICIAN'S NAME (Type) H. Thomas Foley, M.D.											
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF 5-7-66											
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery											
23d. LOCATION (City, town or county) (State) Bel Air, Md.											
24. FUNERAL DIRECTOR Lee Funeral Home ADDRESS Washington, D.C.											
25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE Charles Judge											
DATE MAY 10 1966											

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

Reg. Dist. No.

07155

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cherry Chase Md.		c. LENGTH OF STAY IN 1b SINCE APRIL 1, 1966		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7103 CONNECTICUT AVE				d. STREET ADDRESS 1425 Rhode Island Ave N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle SMITH Last HOLLAND				4. DATE OF DEATH Month May Day 13 Year 1966			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 4 - 1878	9. AGE (In years last birthday) yrs. 87	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED.		10b. KIND OF BUSINESS OR INDUSTRY US Govt. Dept of Interior		11. BIRTHPLACE (State or foreign country) ORLEAN VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George L. HOLLAND				14. MOTHER'S MAIDEN NAME JACQUELINE M. Payne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO ---		17. INFORMANT JAC H. Bushong Address NEPHEW - 7103 CONN. AVE. Cherry Chase Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE - 7824 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)						INTERVAL BETWEEN ONSET AND DEATH 12 HRS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 , 19____, to 5-13 , 19 66 , that I last saw the deceased alive on May 12 , 19 66 , and that death occurred at 2:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Irene G. Tamagna M.D. 7101 CONNECTICUT AVE Cherry Chase PHYSICIAN'S NAME (Type) IRENE G. TAMAGNA M.D. 5-13-66							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-16-66		22c. NAME OF CEMETERY OR CREMATORY Orlean Meth. Church		22d. LOCATION (City, town, or county) (State) Orlean Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph. Gaudet's Sons				24a. REC'D BY REGISTRAR 5730 Wisconsin Ave. N.W. Washington, D.C.		24b. REGISTRAR'S SIGNATURE MAY 18 1966 g. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR #15 (4)
2DM 1/65

MAY 31 1966											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
C7156											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>✓</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>						c. LENGTH OF STAY IN 1b <u>5 hrs & 5 mins</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM & HOSPITAL</u>						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>					
f. STREET ADDRESS <u>633 Hamilton Street, N.W.</u>						g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Bernice</u> Middle <u>Almeta</u> Last <u>Saunders Howard</u>						4. DATE OF DEATH Month <u>MAY</u> Day <u>25</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>8-2-18</u>		9. AGE (In years last birthday) <u>46 47 yrs.</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u> Hours <u>47</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK - TREAS. DEPT.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>ALPHEUS SAUNDERS</u>					
14. MOTHER'S MAIDEN NAME <u>MARY HARVEY</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					
16. SOCIAL SECURITY NO. <u>NONE</u>						17. INFORMANT <u>UNKNOWN CHDET.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pleural effusion</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic carcinoma</u> DUE TO (c) <u>Carcinoma of breast</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 1/2 yrs.</u> <u>4 yrs.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>March 3, 1966</u> , to <u>May 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 25, 1966</u> , and that death occurred at <u>5:50 P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John D. Guinness MD</u>						22b. DATE SIGNED <u>5/26/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>John D. Guinness, M.D.</u>						22d. ADDRESS <u>1601 16th St NW DC</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5-31-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Cambridge, Massachusetts</u>				24. FUNERAL DIRECTOR <u>John T. Rhines Company</u> <u>3015 12th Street, N. E.</u>							
25a. REC'D BY REGISTRAR <u>MAY 31 1966</u>						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN 1b <i>DOA</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring Maryland</i> d. STREET ADDRESS <i>1927 Lytle Houseville Road.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Launa Elizabeth Hudson</i>					4. DATE OF DEATH Month <i>May</i> Day <i>28</i> Year <i>1966</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-22-19</i>		9. AGE (In years last birthday) <i>46</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>(Washington) Motor Hotel Max Meadows, Virginia</i>		11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Edgar Hudson</i>					14. MOTHER'S MAIDEN NAME <i>Jackson, Blanche</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) <i>None</i>					16. SOCIAL SECURITY NO. <i>229-09-2369</i>		17. INFORMANT <i>Leo Peter Rogers - 1429 Madison St. NW D.C.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Exsanguination - Transection of</i> <i>Thoracic Aorta - Auto. Accident -</i> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Sudden</i> OUE TO (c) <i>Sudden</i>									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>driving car made U-turn struck by another auto</i>				
20c. TIME OF INJURY Month, Day, Year Hour <i>11:30</i> p.m. <i>5/28</i> 1966			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work et work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway 240</i>		20f. (City or town) (County) (State) <i>Bethesda Mont. Md.</i>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John G. Ball</i>					22. DATE SIGNED M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>5/30/66</i>				
EXAMINER'S NAME (Type) <i>John G. Ball</i> <i>7936 Old Georgetown Rd., Bethesda, Md.</i> Address (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>June 1, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>West End Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Wytheville, Virginia</i>		
24. FUNERAL DIRECTOR <i>Warner E. Humphrey, Inc. 8434 Georgia Avenue Silver Spring, Md.</i>						25a. REC'D BY REGISTRAR <i>JUN 2 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

Estimated time of death 10:00 a.m.

MEDICAL CERTIFICATION

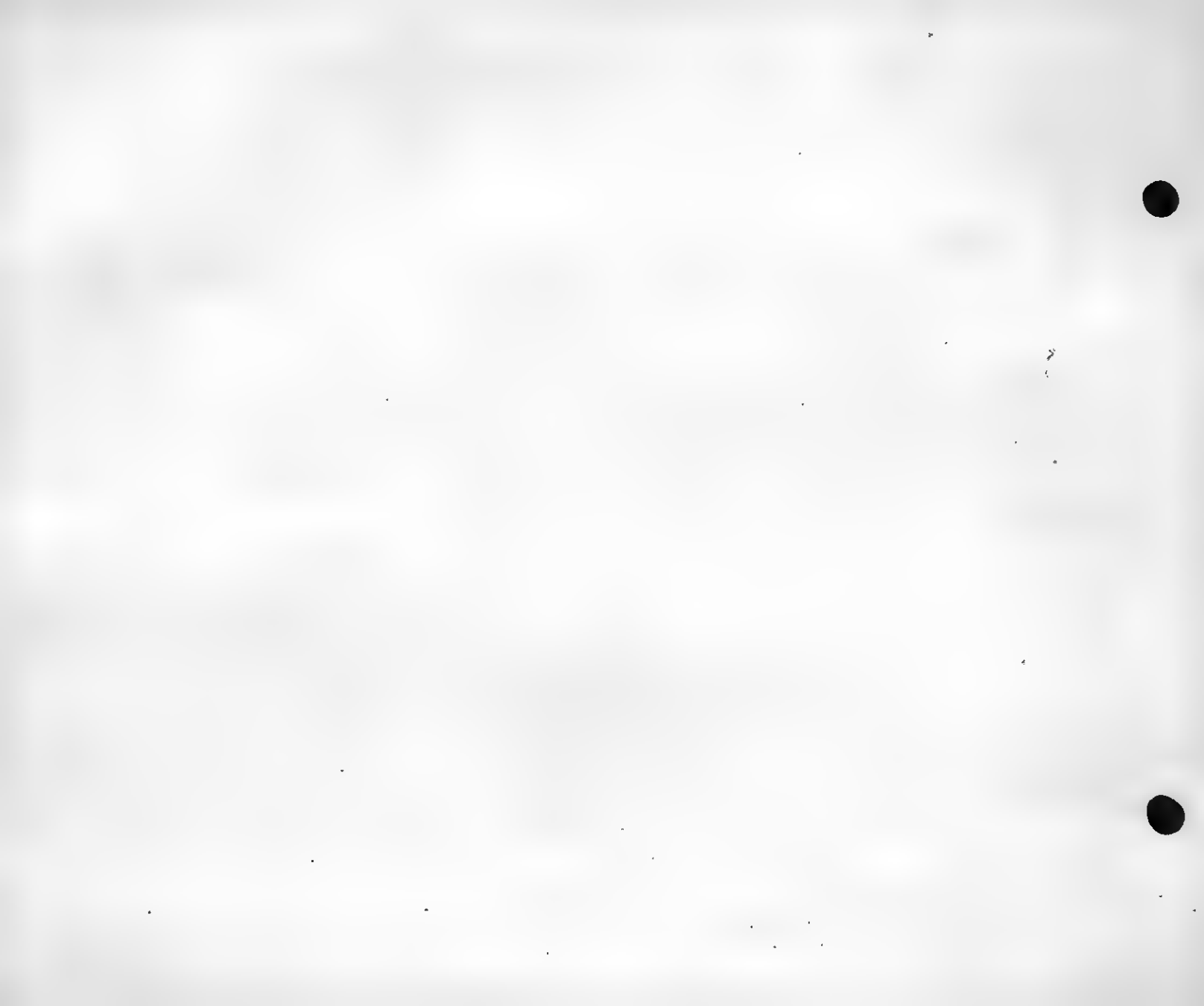
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
07158									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus c. LENGTH OF STAY IN 1b Damascus d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 26420 Ridge Rd.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus d. STREET ADDRESS 26420 Ridge Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Ina Middle Rhea Last Hughes			4. DATE OF DEATH Month May Day 17 Year 1966						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 27, 1892		9. AGE (In years last birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Statistician			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William C. Brown					14. MOTHER'S MAIDEN NAME Ella E. Kendig				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 580-52-9165		17. INFORMANT Walter E. Hughes Address 25101 Oak Dr. Damascus, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO as manifested by Acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH Years ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Two previous Myocardial Infarction								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Feb. 1966 to MAY 17, 1966 , that (I) (we) last saw the deceased alive on 2-15 1966 , and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE Jack Schumacher M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-19-66		
22c. PHYSICIAN'S NAME (Type) Jack Schumacher, MD.					22d. ADDRESS 105 Russell Ave., Gaithersburg, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 20, 1966		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) (State) Suitland, Md.		
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.					25a. REC'D BY REGISTRAR MAY 23 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Authorization given by County Medical Examiner, Dr. B. Roof

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
07167															
07159															
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN 1b <i>10 yrs.</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>26 Philadelphia Avenue</i>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> d. STREET ADDRESS <i>26 Philadelphia Ave</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <i>Ellen</i> Middle <i>C</i> Last <i>Hurley</i>			4. DATE OF DEATH Month <i>May</i> Day <i>29</i> Year <i>1966</i>			5. SEX <i>F</i>			6. COLOR OR RACE <i>W</i>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>May 12 1912</i>			9. AGE (In years last birthday) <i>54</i> yrs.			IF UNDER 1 YEAR Months Days Hours Min.			IF UNDER 24 HRS.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Falmouth, Virginia</i>				12. CITIZEN OF WHAT COUNTRY? <i>American</i>			
13. FATHER'S NAME <i>Austin Cowne</i>						14. MOTHER'S MAIDEN NAME <i>Unknown</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>				16. SOCIAL SECURITY NO. <i>—</i>				17. INFORMANT <i>Mrs. Loretto Hurley</i> Address <i>26 Philadelphia Ave, Takoma Park, Md</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Atherosclerosis, generalized</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>6 yrs</i>															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , to <i>May 26</i> , 1966, that (I) (we) last saw the deceased alive on <i>May 26</i> 1966, and that death occurred at <i>1:17</i> M, from the causes and on the date stated above.															
22a. SIGNATURE <i>Allen S. Gardner, M.D.</i>										22b. DATE SIGNED <i>May 29, 1966</i>					
22c. PHYSICIAN'S NAME (Type) <i>Allen S. Gardner</i>										22d. ADDRESS <i>1807 Eidon Lane Silver Spring, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <i>JUNE 1, 1966</i>			23c. NAME OF CEMETERY OR CREMATORY <i>MCWINTZ CEM.</i>			23d. LOCATION (City, town or county) (State) <i>WASHINGTON D.C.</i>						
24. FUNERAL DIRECTOR <i>Charles Judge</i> ADDRESS <i>254 GARROLLS NW</i>						25a. REC'D BY REGISTRAR <i>MAY 31 1966</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



11. 11. 1901

11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>													
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>27 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital of Silver Spring</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> d. STREET ADDRESS <u>1810 METZGER RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <u>David Shaffer Jarvis</u>			4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1966</u>		5. SEX <u>MALE</u>			6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>8/14/33</u>			
9. AGE (In years last birthday) <u>32 yrs.</u>			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IBM</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>David Jarvis III</u>					14. MOTHER'S MAIDEN NAME <u>Eva M. Maria</u>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>204-74-7088</u>		17. INFORMANT <u>David Jarvis III Lake Park, Florida</u>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Glomerulonephritis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town)				(County)					
(State)				21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> , to <u>May 20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 15</u> , 19 <u>66</u> , and that death occurred at <u>4:30</u> P.M., from the causes and on the date stated above.									
22a. SIGNATURE <u>Morton Altschuler</u>												22b. DATE SIGNED <u>5-20-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Morton Altschuler</u>						22d. ADDRESS <u>9205-New Hope Ave. Silver Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>May 24 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Philadelphia, Penna.</u>				23d. LOCATION (City, town or county) <u>Adelphi</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, 910 Silver Spring, Md.</u>						25a. REC'D BY REGISTRAR <u>MAY 24 1966</u>						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07170

07162

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>DC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keensington</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Correll Hall Sanitarium</u>				d. STREET ADDRESS <u>2733 Ordway St. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Helan</u> First <u>M.</u> Middle <u>Jarecki</u> Last				4. DATE OF DEATH <u>5</u> <u>17</u> <u>1966</u> Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/27/89</u>	
9a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <u>Sioux City, Iowa</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Stephen Johnston</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Kennelly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>561-20-0728A</u>			
17. INFORMANT <u>Dorothea M. Jarecki</u>				Address <u>same as #3</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/17/66</u> to <u>5/17/66</u> , that (I) (we) last saw the deceased alive on <u>5/17/66</u> and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>John B. Umhan</u>				22b. DATE SIGNED <u>5/17/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAN</u>				22d. ADDRESS <u>8805 Conn. Ave. Ch. Ch. Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE THEREOF <u>5/19/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Dos Angeles, Calif</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. DATE <u>MAY 19 1966</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

27163

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 weeks 6 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				e. STREET ADDRESS <u>328 Highview Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Elliott</u> Last <u>Jefferson</u>				4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4, 1893</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>William Jefferson</u>				14. MOTHER'S MAIDEN NAME <u>Hugenia Eustic</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>313-16-3470</u>		17. INFORMANT <u>Nancy Dykstra</u> Address <u>407 Ellsworth Drive Silver Spring, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus (from left leg)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auricular fibrillation</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>20 days</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1961</u> to <u>May 5, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 4, 1966</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Sydney Leventhal</u>				22b. DATE SIGNED <u>May 5, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Sydney Leventhal, M.D.</u>				22d. ADDRESS <u>9210 Colesville Rd., Silver Spring Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9 May 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>MAY 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

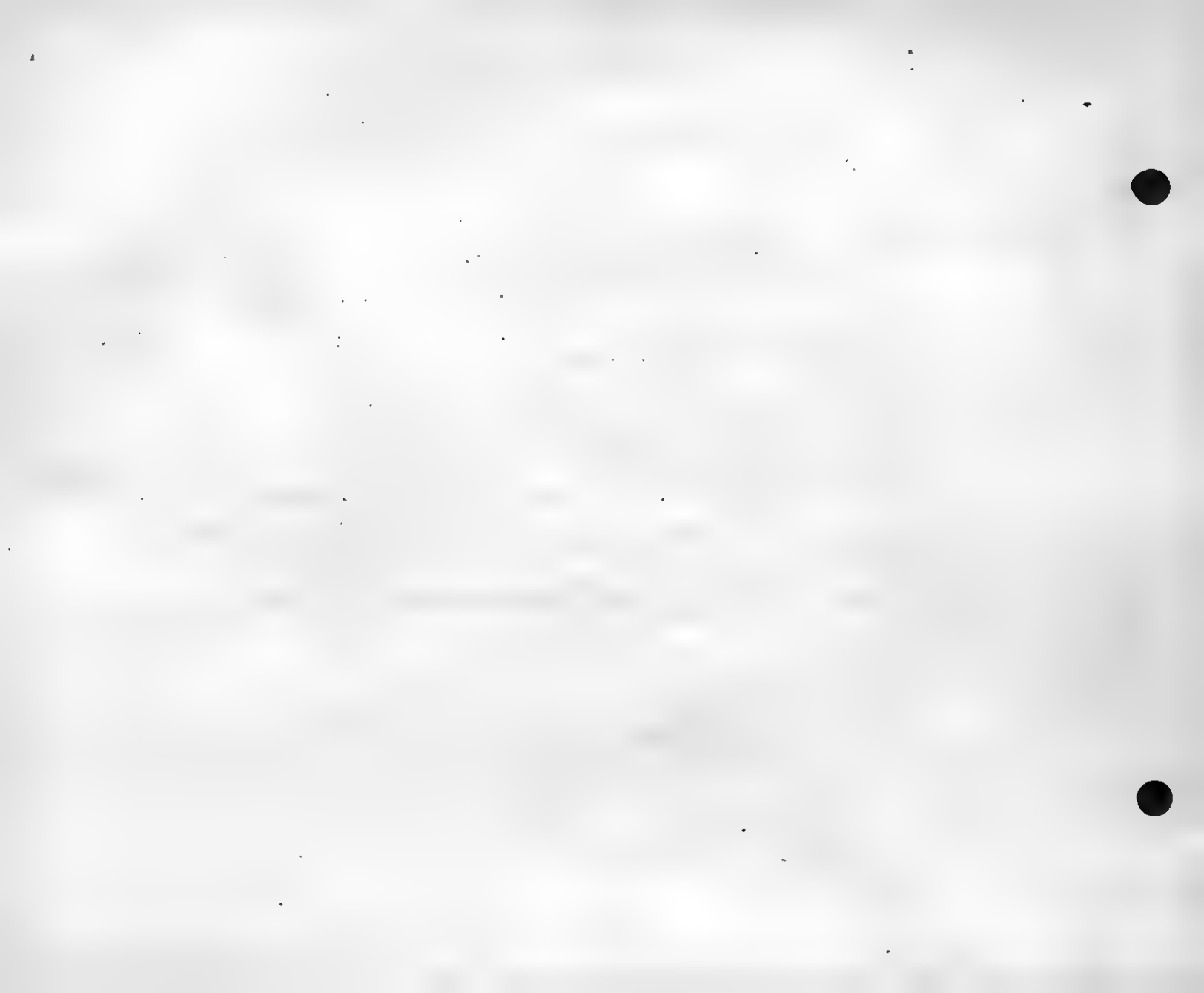
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item #3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 20&21 Film G378 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DICKERSON</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHARLESTOWN</u> d. STREET ADDRESS <u>RD # I</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT H. JENKS</u>		4. DATE OF DEATH Month Day Year <u>May 8 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-41</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lineman</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>Paul Jenks</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Bunts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>131-32-8109</u>	
17. INFORMANT <u>Paul Jenks, father, same item # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INJURIES Multiple SEVERE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Fall from Electrical Tower (100 ft)</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET OF DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased fell from electrical tower when part broke off</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7:20</u> p.m. <u>5/8</u> 19 <u>66</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Field</u>	20f. (City or town) (County) (State) <u>Dickerson Montr. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Peap</u> M.D.		22. DATE SIGNED <u>May 8, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. PEAP, M.D.</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/11/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Riverside cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Whitney Point, N.Y.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR, 25b. REGISTRAR'S SIGNATURE <u>Rockville, Maryland</u> <u>Charles Judge</u> DATE <u>MAY 10 1966</u>	



TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07173

07166

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>FAIRLAND</u> c. LENGTH OF STAY IN 1b <u>LIFE</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2326 FAIRLAND RD.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND - SILVER SPRING</u> d. STREET ADDRESS <u>2326 FAIRLAND ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DOROTHY</u> First Middle Last 4. DATE OF DEATH <u>MAY 26 1966</u> Month Day Year		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 19-1897</u> 9. AGE (In years, if UNDER 1 YEAR, if UNDER 24 HRS. last birthday) <u>69</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HT HOME</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MONTGOMERY, MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>WILSON G. JOHNSON</u> 14. MOTHER'S M maiden name <u>LIZZIE VIOLA KEILER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>SARAH JOHNSON</u> Address <u>2326 FAIRLAND ROAD, SILVER SPRING, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Acute coronary occlusion</u> <u>arteriosclerotic heart disease</u> <u>diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>obesity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER). 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> 20f. (City or town) (County) (State)		21. I certify that (1) (this hospital) attended the deceased from <u>June 26, 1963</u> to <u>May 26, 1966</u> , that (2) (we) last saw the deceased alive on <u>Feb. 17, 1966</u> , and that death occurred at <u>5:00</u> A.M. from the causes and on the date stated above.		22a. SIGNATURE <u>John R. Spencer</u> 22b. DATE SIGNED <u>5-26-66</u> 22c. PHYSICIAN'S NAME (Type) <u>JOHN R. SPENCER</u> 22d. ADDRESS <u>BURTENVILLE, M.D.</u> 22e. MED. DIRECTOR <input checked="" type="checkbox"/> MED. STAFF PHYS. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>MAY 28-1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ST MARKS CHURCH CEMETERY</u> 23d. LOCATION (City, town or county) (State) <u>FAIRLAND MONTGOMERY MD.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>J. ARTHUR WALTERS</u> 25. REG. BY REGISTRAR <u>REC'D BY REGISTRAR</u> 26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		27. DATE <u>MAY 31 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b Rockville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 208 Frederick Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 212 Lincoln Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth G. Middle Johnson Last 4. DATE OF DEATH Month May Day 21 Year 1966		5. SEX F 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 15, 1907 9. AGE (In years last birthday) 58 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Andrew Warfield 14. MOTHER'S MAIDEN NAME Ella Dorsey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Ella Holland (Daughter) Address Item #2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 15 min DUE TO (b) Hypertensive heart disease 15 years DUE TO (c) Angina Pectoris 7 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1952 , 19, to 5/21 , 19 66 , that (I) (we) last saw the deceased alive on 5/17 , 19 66 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE W. H. Hall M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 5/22/66		22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5/25/66 23c. NAME OF CEMETERY OR CREMATORY Lincoln Park 23d. LOCATION (City, town or county) (State) Rockville, Md.		24. FUNERAL DIRECTOR Snowden Fun. Home ADDRESS Rockville, Md. 25a. REC'D BY REGISTRAR MAY 25 1966 25b. REGISTRAR'S SIGNATURE f Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery-</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Woods - in Kenwood off Kennedy</u>		e. STREET ADDRESS <u>5117 Fairglan Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Steven</u> Middle <u>Francis</u> Last <u>Johnston</u>		4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>9</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis Rinehart Johnston</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth R. Johnston</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Samuel Del Vecchio</u>		Address <u>5506 Kenilworth Ave. Riverdale, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Stab. wounds of Larynx + Neck</u> DUE TO (c) <u>Sudden</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stabed By Assassin - sex crime -</u>		
20c. TIME OF INJURY Month, Day, Year Hour <u>3:30</u> p.m. <u>5/8/66</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Woods.</u>	20f. (City or town) (County) (State) <u>Bethesda Mont. Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>5/9/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/11/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>Jos. Gawler's Sons, Inc., Wash., D.C.</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		MAY 12 1966	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02176

Item 2 Film 506 64-10-56 - 101

27169

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg c. LENGTH OF STAY IN lb 12 yrs 8 Mo d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Asbury Methodist Home		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel Savage d. STREET ADDRESS 17777	
3. NAME OF DECEASED (Type or print) Sarah R. Jones First Middle Last		4. DATE OF DEATH May 20 1966 Month Day Year	
5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1881 9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Guilford, Howard Co., Md. 12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME David Alonzo Bell 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no 16. SOCIAL SECURITY NO. 213-01-7737A		14. MOTHER'S MAIDEN NAME Annie Vincent Jones 17. INFORMANT Asbury Methodist Home, Gaithersburg, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 5 yrs. 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/1/66 19 to 5/20/66 19 , that (I) (we) last saw the deceased alive on 5/18/66 19 , and that death occurred at 235 M, from the causes and on the date stated above.			
22a. SIGNATURE Henry C. Secor MD		22b. DATE SIGNED 5/20/66	
22c. PHYSICIAN'S NAME (Type) Henry C. Secor MD		22d. ADDRESS 5413 Cedar La. Bethesda Md	
23a. BURIAL, CREMATION, DATE THEREOF 5/23/66		23b. NAME OF CEMETERY OR CREMATORY Forest Lincoln	
23c. LOCATION (City, town or county) (State) Blacksburg, and		23d. REC'D BY REGISTRAR May 24 1966	
24. FUNERAL DIRECTOR'S SIGNATURE EC Dutton		25. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
SM 1/65

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA (RURAL)</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Hospital, Bethesda, Md.</u>		e. STREET ADDRESS <u>5122 White Flint Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Eleanor</u> Middle <u>True</u> Last <u>JORDAN</u>		4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19 1905</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (In years last birthday) <u>61 yrs.</u>
10. FATHER'S NAME <u>John Preston TRUE</u>		11. BIRTHPLACE (State or foreign country) <u>Newton, Massachusetts</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. MOTHER'S MAIDEN NAME <u>Lillian Larcie CRAWFORD</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		15. SOCIAL SECURITY NO. <u>Unknown</u>	
16. INFORMANT (Husband) <u>Franklin E. JORDAN/Flint Dr. Kensington</u>		17. ADDRESS <u>5122 White</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Calcific aortic valvular stenosis.</u> 4211 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Keap</u>		22. DATE SIGNED <u>May 3, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <u>5122 White Flint Drive, Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>5-6-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>May 9 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

07171

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>20 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>6208 Misc. Ave. N.W.</i>	
3. NAME OF DECEASED (Type or print) <i>Winifred Maxine Jurrians</i>		4. DATE OF DEATH Month <i>May</i> Day <i>13</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/8/1901</i>
9. AGE (In years last birthday) <i>65</i> yrs.		IF UNDER 1 YEAR Months <i>3</i> Days <i>5</i> Hours <i></i> Min <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sociologist</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Lisbon, North Dakota</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Ray Jurrians</i>		14. MOTHER'S MAIDEN NAME <i>Jurrians (Unknown)</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>NOT AVAILABLE</i>	
17. INFORMANT <i>George Jurrians (Bro.)</i>		Address <i>Grand Rapids, Mich.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i> DUE TO (b) <i>Pneumonia</i> DUE TO (c) <i>Anemia, Gastrointestinal Hemorrhage</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>May 2, 1966</i> , to <i>May 11, 1966</i> , that (I) (we) last saw the deceased alive on <i>May 11, 1966</i> , and that death occurred at <i>6:15 A.M.</i> from causes on and on the date stated above			
22a. SIGNATURE <i>John B. Umhau</i>		22b. DATE SIGNED <i>5/13/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>JOHN B. UMHAU MD</i>		22d. ADDRESS <i>8805 Conn Ave. Chevy Chase Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>MAY 17, 1966</i>	23c. NAME OF CEMETERY OR CREMATORY <i>WINCHESTER CEMETERY</i>	23d. LOCATION (City or Town) (County) (State) <i>KENT COUNTY, MICHIGAN</i>
24. FUNERAL DIRECTOR <i>M.W. HYSOING CO. INC.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. DATE <i>MAY 16 1966</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C7172

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN <u>b</u> <u>1 hr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>2104 Coleridge Drive</u>	
3 NAME OF DECEASED (Type or print) First <u>Savas</u> Middle <u>Vasili</u> Last <u>Kamburis</u>		4 DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7/2/1906</u>
9 AGE (In years last birthday) <u>67</u> yrs		10 UNDER 24 HRS Months <u>1</u> Days <u>19</u> Hours <u>56</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restauranteur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11 BIRTHPLACE (State or foreign country) <u>Rhodes, Greece</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Vasili Kamburis</u>		14. MOTHER'S MAIDEN NAME <u>Despina</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>16</u>	
17 INFORMANT <u>Wife,</u> <u>Anthe Kamburis</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Coronary Artery Heart Disease</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Read</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. READ</u>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>May 2, 1966</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BIRTHPLACE (City or town) (County) (State) <u>Washington, D. C.</u>		23b. LOCATION (City or town) (County) (State) <u>Washington, D. C.</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Washington, D. C.</u>	
24 FUNERAL DIRECTOR <u>The S. H. Hines Co</u>		25a. REC'D BY REGISTRAR <u>MAY 4 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>		25c. REGISTRAR'S SIGNATURE <u>James Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>41 days</u>		d. STREET ADDRESS <u>1036 University Blvd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FANNY</u> First Middle Last		4. DATE OF DEATH <u>5-25-1966</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-86</u> 8 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FREEDMAN, MORRIS</u>		14. MOTHER'S MAIDEN NAME <u>HANNAH ISRAEL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Hosp Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction due to a/cvd</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(u) Bronchopneumonia</u> (b) <u>chronic cholecystitis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from <u>april 14, 1966</u> , to <u>may 25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>may 24</u> , 19 <u>66</u> , and that death occurred at <u>10:45</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Gene U. Cohen M.D.</u>		22b. DATE SIGNED <u>May 25, 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>GENE U. COHEN, M.D.</u>		22d. ADDRESS <u>1106 SPRING ST., SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-29-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Cem.</u>	23d. LOCATION (City, town or county) (State) <u>HYATTSVILLE MD</u>
24. FUNERAL DIRECTOR <u>Holbrook Funeral Home</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
ADDRESS <u>4217-9th St. NW</u>		25b. REGISTRAR'S SIGNATURE	

FOR STATE HEALTH DEPT

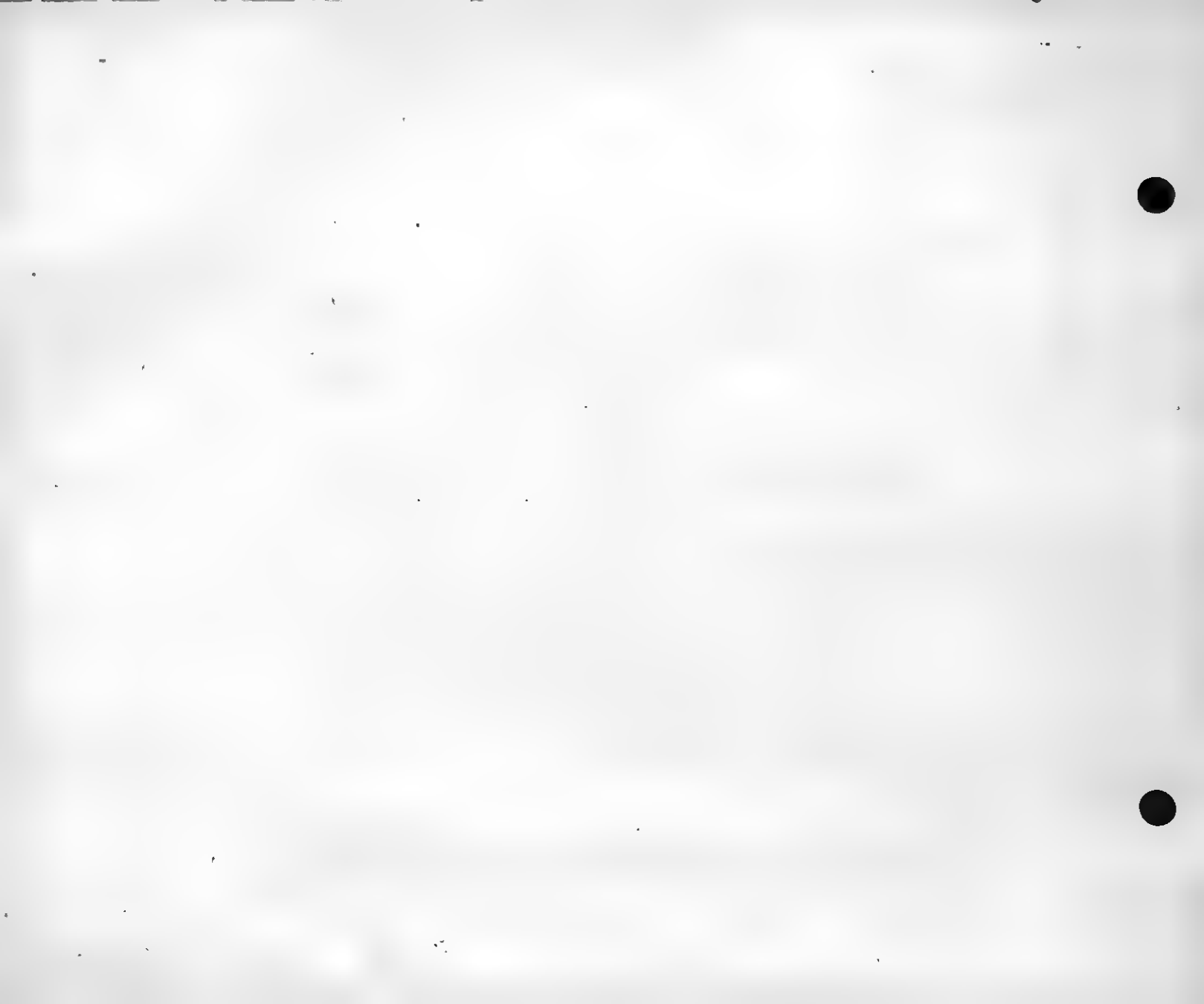
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07181		07174	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN ID <u>3 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> d. STREET ADDRESS <u>4410 DAHILL Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>M</u> Last <u>KAUFFMAN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-34</u> yrs. <u>31</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CRUSHED ROCKVILLE STONE</u>	9. AGE (In years last birthday) <u>6</u> yrs. <u>14</u> months <u>14</u> days <u></u> hours <u></u> min.
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Norman Harvey</u>		14. MOTHER'S MAIDEN NAME <u>Jean E. Nye</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(no)</u>		16. SOCIAL SECURITY NO. <u>210-26-7145</u>	17. INFORMANT <u>Elena - wife</u> Address <u>same</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis, pneumococcal</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u>		22. DATE SIGNED <u>5/4/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/7/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>
23d. LOCATION (City, town or county) <u>Shippensburg, Cumberland Co.</u>		(State) <u>Pennsylvania</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR <u>MAY 6 1966</u>	
ADDRESS <u>1331 Rockville Pike Rockville, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<div> <div>1</div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div> <div>07182</div> <div>07175</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> </div>																									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Martinsburg</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>along Electric Power Lines</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>West Virginia</u> COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Morefield</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																				
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Richard</u> Last <u>Keller</u>			4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1966</u>		5. SEX <u>M.</u>			6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>															
8. DATE OF BIRTH <u>9/19/1933</u>			9. AGE (in years last birthday) <u>32</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.					10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electric Line Man</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.																							
Months	Days	Hours	Min.																						
13. FATHER'S NAME <u>George W. Keller</u>					14. MOTHER'S MAIDEN NAME <u>Felkner Simmons</u>																				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>Borean</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Beatrice Keller</u> Address <u>As Above</u>																				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u> 42-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary Arterio Sclerosis.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2</u> years															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____																						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____																		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																									
ACTUAL SIGNATURE <u>John B. Ball</u>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Bethesda, Md.</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5/31/66</u> Address (Street, city, town, or county) _____																				
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>																									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>June 2, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u>			23d. LOCATION (City, town or county) <u>Morefield West Virginia</u> (State) _____																	
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>			ADDRESS <u>Bethesda Maryland</u>			25a. REC'D BY REGISTRAR <u>JUN 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																	

C7183

CERTIFICATE OF DEATH

07176

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY in lb 22 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
		d. STREET ADDRESS 6 Wesley Court	
3. NAME OF DECEASED (Type or print) First Jonathan Sandy Middle Kemp Last Kemp		4. DATE OF DEATH Month 5 Day 23 Year 19 66	
5. SEX Male	6. CO. OR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/27/84
9. AGE (In years last birthday) yrs 81		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret red) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Kemp		14. MOTHER'S MAIDEN NAME Annie Baker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital records		Address Olney, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 hrs. CEREBRAL VASCULAR ACCIDENT CEREBRAL ARTERIOSCLEROSIS GENERAL ARTERIOSCLEROSIS YES YES	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSION - PYELONEPHRITIS - UREMIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCTOBER 63 to 5/23 1966 , that (I) (we) lost saw the deceased alive on 5/23 1966 , and that death occurred at 7P M, from causes and on the date stated above.			
22a. SIGNATURE Donald R. Lewis		22b. DATE SIGNED 5/23/66	
22c. PHYSICIAN'S NAME (Type) Donald R. Lewis		22d. ADDRESS Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-26-66	
23c. NAME OF CEMETERY OR CREMATORY Laytonsville		23d. LOCATION (City or town) (County) (State) Laytonsville, Mont., Md.	
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonsville, Md.	
25a. REC'D BY REGISTRAR MAY 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please to have carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

CERTIFICATE OF DEATH

07184

07177

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY A. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 9 Riverbay Rd., Cape St. Clair	
3. NAME OF DECEASED (Type or print) First William Middle Medford Last KEMSKE		4. DATE OF DEATH Month May Day 13 Year 1966	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1921
9. AGE (in years) 45 yrs		10. IF UNDER 1 YEAR Months 1 Days 13 Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Ret	
11. BIRTHPLACE (County & State, or foreign country) Wilmington, Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Emil J. Kemske		14. MOTHER'S MAIDEN NAME Merle Connolly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes Nov 41-Dec. 65		16. SOCIAL SECURITY NO	
17. INFORMANT Clair, Annapolis Address Maryland Mrs. Mary Kemske, 9 Riverbay Road, Cape St./			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Malignant Melanoma with metastases DUE TO 1704 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from May 8 , 1966, to May 13 , 1966, that he (we) last saw the deceased alive on May 13 , 1966, and that death occurred at 1252PM , from causes and on the date stated above.			
22a. SIGNATURE Robert H. Easterday		22b. DATE SIGNED 13 May 1966	
22c. PHYSICIAN'S NAME (Type) Robert H. Easterday, M. D.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL, etc. Cremation	23b. DATE THEREOF 5-14-66	23c. NAME OF CEMETERY OR CREMATORY St. Lincoln	23d. LOCATION (City or Town) (County) (State) Bladensburg MD.
24. FUNERAL DIRECTOR John M. Taylor, 147-149 Gloucester St. Annapolis Md.		25a. REC'D BY REGISTRAR MAY 17 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

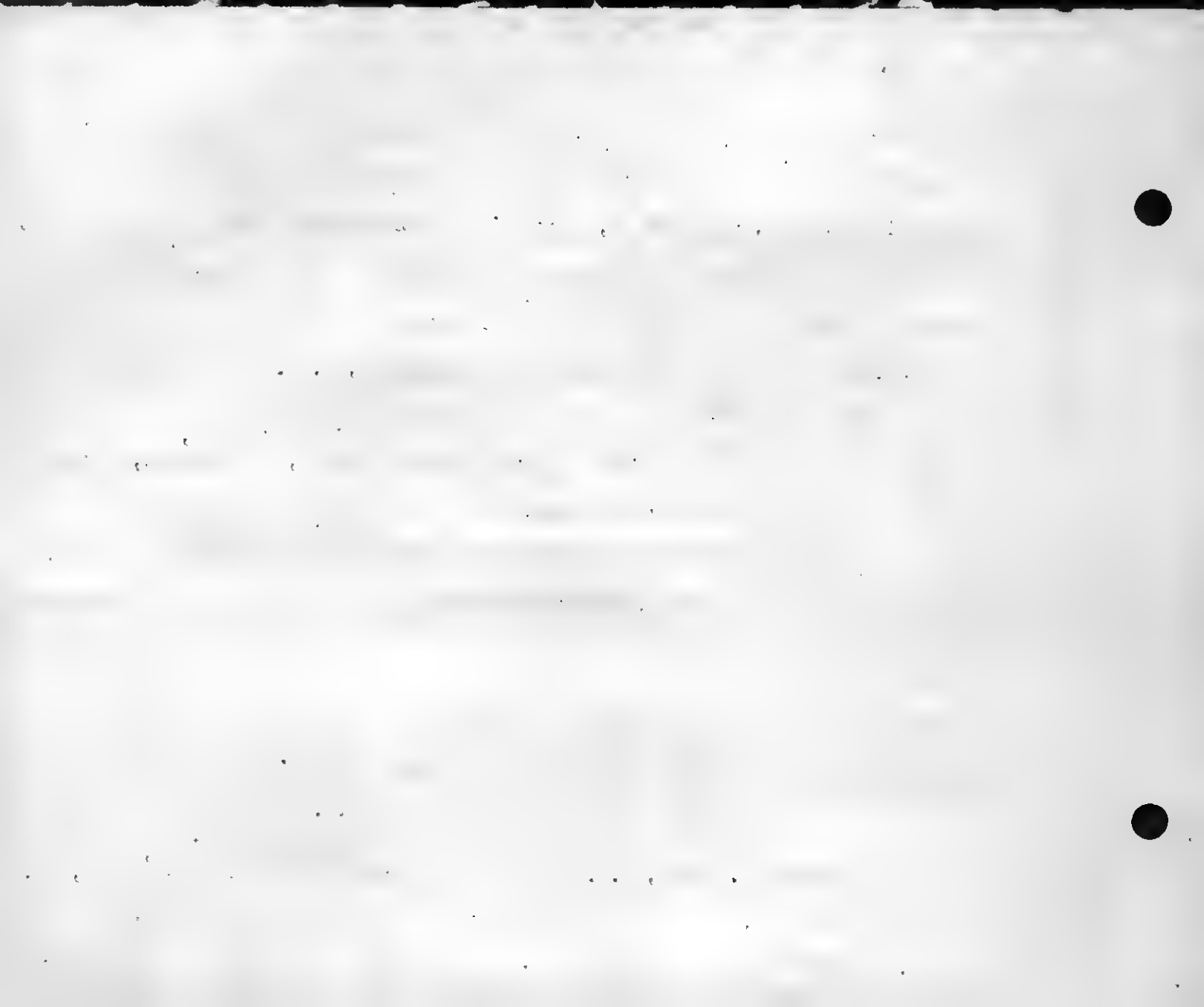
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
07185									
07178									
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges ✓				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 12 Days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lanham			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Maryland									
3. NAME OF DECEASED (Type or print) First Albert Middle Joseph Last Keppler					4. DATE OF DEATH Month May Day 7 Year 19 66				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 April 1958		9. AGE (In years last birthday) 8 yrs. IF UNDER 1 YEAR: Months 8 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert John Keppler					14. MOTHER'S MAIDEN NAME Helen Kneisly				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records, The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO and Cerebral Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Deep coma from Central Nervous System Leukemia/ DUE TO (c) Acute Lymphocytic Leukemia									INTERVAL BETWEEN ONSET AND DEATH 12 days 30 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that he (this hospital) attended the deceased from 25 April, 19 66 to 7 May , 19 66 , that he (we) last saw the deceased alive on 7 May , 19 66 , and that death occurred at 5:25M , from the causes and on the date stated above.									
22a. SIGNATURE <i>Robert C. Gallo</i>					22b. DATE SIGNED 7 May 1966				
22c. PHYSICIAN'S NAME (Type) Robert C. Gallo, M.D.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 10, 1966		23c. NAME OF CEMETERY OR CREMATOR Gate of Heaven		23d. LOCATION (City, town or county) (State) "heaton Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville Md.					25a. REC'D BY REGISTRAR DATE MAY 10 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>25 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10207 Southmoor Drive</u>		e. STREET ADDRESS <u>10207 Southmoor Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Doris</u> Middle <u>Marie</u> Last <u>Lange</u>		4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE (in years last birthday) <u>61 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Leonard Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Marea D. Allen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>William B. Whichard</u>		Address <u>Engle Drive Wallingford, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> <u>4201</u> DUE TO (b) <u>Coronary Artery Heart Disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>p.m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		22. DATE SIGNED <u>5/31/1966</u>	
EXAMINER'S NAME (Type) <u>Belden R. Reap</u>		Address (Street, city, town, or county) <u>11502 Grandview Ave. Chantilly, Va.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 1, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Prince George Co., Md.</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>JUN 3 1966</u>	
Address <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
 HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (In case of corporate limits, write RURAL and give nearest town) Takoma Park		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
c. LENGTH OF STAY in 1b 11 2		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San + Hosp.		d. STREET ADDRESS 902 Linwood St	
3 NAME OF DECEASED (Type or print) Nicola Anthony Lanzillotti		4 DATE OF DEATH Month May Day 11 Year 1966	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 12, 1888
9 AGE (in years last birthday) 77 yrs		10 IF UNDER 1 YEAR Months 77 Days 11 Hours 19 Min 66	
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Retired		10b KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (State or foreign country) USA		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME ANTHONY LANZILLOTTI		14 MOTHER'S MAIDEN NAME CONSTANCE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 50-22-2801	
17 INFORMANT Charles Judge		Address 2006 11th St	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO (b) Coronary Artery Heart Disease DUE TO (c) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			19 WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Read M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. READ M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED May 11, 1966		Address (Street, city, town, or county)	
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF 11 MAY 1966	23c NAME OF CEMETERY OR CREMATORY St. Elizabeth's	23d LOCATION (City or town) (County) (State) St. Elizabeth's
24 FUNERAL DIRECTOR Charles Judge		ADDRESS 1400 E. 11th St	
25a REC'D BY REGISTRAR MAY 16 1966		25b REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
GM 1/66

(M)

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07188

07181

1 PLACE OF DEATH a COUNTY Montgomery county. b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		2 USUAL RESIDENCE (Where deceased lived, f institution; Residence before admission) a STATE Maryland b COUNTY Montgomery Co.	
c LENGTH OF STAY IN 1b 20 minutes		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Kensington	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital of Sil. Spring		d STREET ADDRESS 10703 Shaftbury Street	
3 NAME OF DECEASED (Type or print) First LENA Middle NMI Last LASKEY		4 DATE OF DEATH Month 5/ Day 31/ Year 1966	
5 SEX female	6 COLOR OR RACE negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH
9 AGE (In years last birthday) 72 yrs		10 UNDER 1 YEAR Months 5/ Days 31/ Hours 19 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) domestic		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Robert Laskey		14 MOTHER'S MAIDEN NAME Amanda Bowie	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO	
17 INFORMANT Rachel Pratt, sister, Kensington, Maryland		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Arteriosclerotic Heart Disease (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Read M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. READ M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 5/31/1966		DEPT. MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 6/4/66	
23c NAME OF CEMETERY OR CREMATORY Ash Memorial		23d LOCATION (City or town) (County) (State) Sandy Spring Md.	
24 FUNERAL DIRECTOR Robert L. Snowden		ADDRESS Rockville, Md.	
25a FIELD REG STAMP JUN 8 1966		25b SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>8 hr. 45 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Alexandria</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> d. STREET ADDRESS <u>403 S. Van Doren St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Jane Elizabeth</u> First Middle Last 5. SEX <u>FE</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>May 19, 1966</u> 9. AGE (In years last birthday) <u>—</u> yrs. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> IF UNDER 24 HRS. Hours <u>8</u> Min. <u>45</u>						10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Montgomery, Maryland U.S.</u> 11. BIRTHPLACE County & State, or foreign country 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>James William Laughlin</u> 14. MOTHER'S MARDEN NAME <u>Maude Jane Krebs</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Maude J. Laughlin</u> Address <u>403 S Van Doren St</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>174X Prematurity</u> Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (c), stating the underlying cause last. <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anoxia</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>—</u>						20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> 20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>					
21. I certify that (I) (this hospital) attended the deceased from <u>May 19, 1966</u> to <u>May 19, 1966</u> that (I) (we) last saw the deceased alive on <u>May 19, 1966</u> and that death occurred at <u>403 S Van Doren St</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>James A. Davis Jr.</u> 22b. PHYSICIAN'S NAME (Type) <u>JAMES A DAVIS JR</u> 22c. ADDRESS <u>8218 WISCONSIN AVE, BETHESDA</u>						22d. DATE SIGNED <u>5/19/66</u> 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> 22f. MED. DIRECTOR <input type="checkbox"/> 22g. STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 5-21-66</u> 23b. DATE THEREOF <u>5-21-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u> 23d. LOCATION (City, town or county) <u>Shamokin, Penna.</u> (State) <u>—</u>						24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Maryland</u> 25a. REC'D BY REGISTRAR <u>MAY 25 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59



UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>		c. LENGTH OF STAY IN 1b <u>2 yrs. 1 mo. 20 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Potomac Manor Nursing Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>A.</u> Last <u>Lee</u>		d. STREET ADDRESS <u>7816 - Old Chester Rd.</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/5/1881</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Road Est. & Engr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Henry Lee</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>678-05-3209</u>	
17. INFORMANT <u>Mrs. Margaret Lee Higdon (above address)</u>		Address <u>(above address)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO (b) <u>congestive failure</u> DUE TO (c) <u>A.S. H.T.</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1965</u> to <u>May 1966</u> that (I) last saw the deceased alive on <u>May 18, 1966</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Marvin Wadler</u>		22b. DATE SIGNED <u>May 20, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>		22d. ADDRESS <u>8218 Wise, Av. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/23/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>1 Collier Manor, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Halley</u>		25. REC'D BY REGISTRAR <u>MAY 24 1966</u>	
ADDRESS <u>Funeral Home Inc. Mt. Rainier, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>	

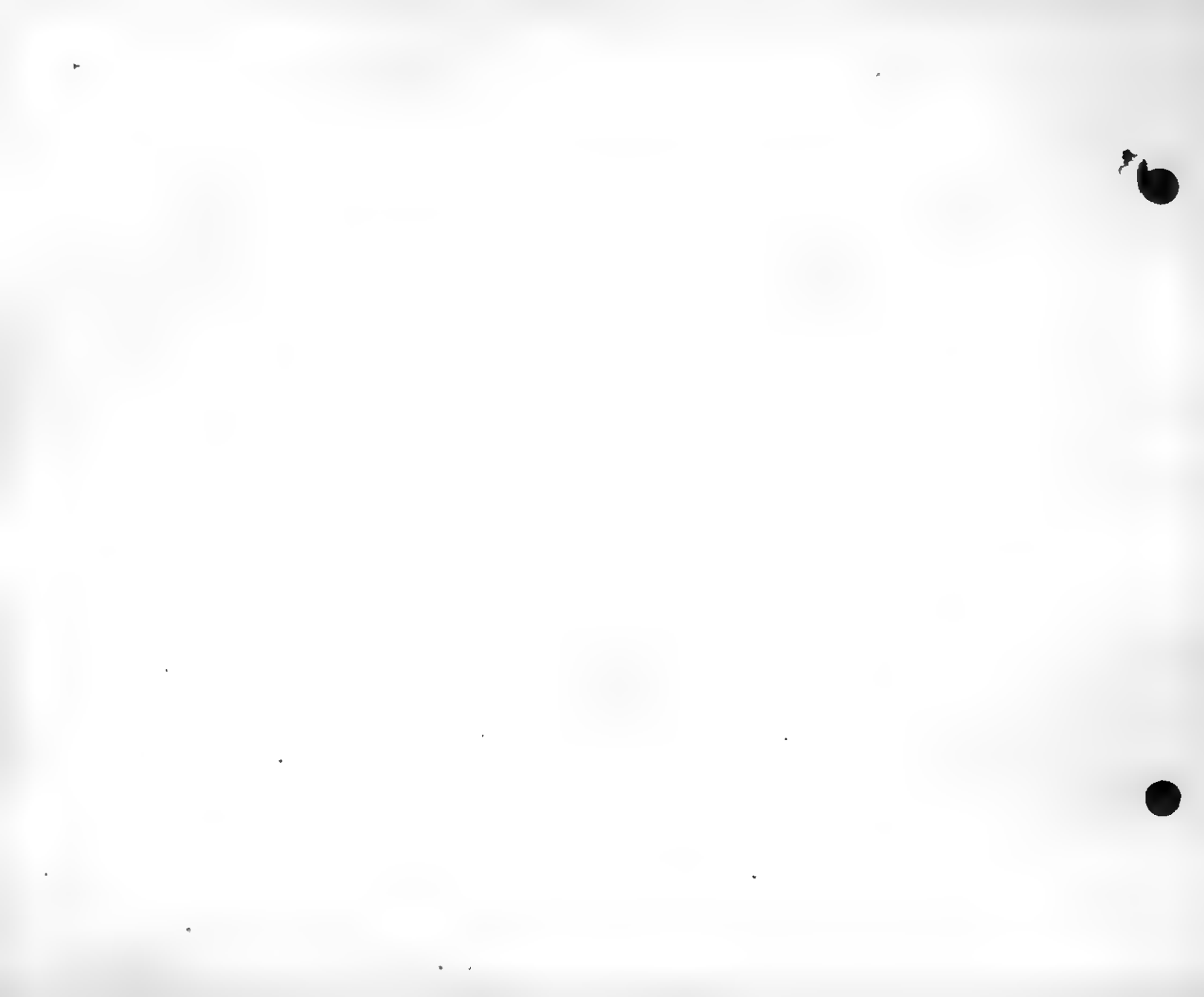
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH



1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) a STATE <u>D.C.</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN 1b <u>D.C.A.</u>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47-3
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hospital</u>		e STREET ADDRESS <u>1512 T St. N.W.</u>	
3 NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>SIMON</u> Last <u>LEE JR.</u>		4 DATE OF DEATH Month <u>5</u> Day <u>20</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-27-20</u>
9 AGE (In years last birthday) <u>46</u> yrs		10 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>HARTSFIELD S.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Willie Simon Lee</u>		14. MOTHER'S MAIDEN NAME <u>Oleane Sutton</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO <u>?</u>	
17 INFORMANT <u>1217 So. Pearson St.</u>		Address <u>Raleigh N.C.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple, extreme fractures of skull with intracranial laceration and hemorrhage.</u> DUE TO (b) <u>of skull with intracranial laceration and hemorrhage.</u> DUE TO (c) <u>laceration and hemorrhage.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PR MAR or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased's head crushed by boom on apartment construction project.</u>	
20c TIME OF INJURY Month, Day Year <u>22</u> <u>5-20</u> 19 <u>66</u>	20d INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office, bus, etc.) <u>Apt. 13 Bldg. Takoma Park Montgom. Md.</u>	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and of my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5/21/66</u>	
23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)	
24 FUNERAL DIRECTOR <u>Morrow & Wood -</u> ADDRESS <u>1622 11th St. N.W.</u>		25a REC'D BY REGISTRAR <u>May 23 1966</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c REGISTRAR'S SIGNATURE	



07192

CERTIFICATE OF DEATH

07185

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5480 Wis. Ave.,		d. STREET ADDRESS 5480 Wis. Ave.	
3. NAME OF DECEASED (Type or print) Plia P Lenart		4. DATE OF DEATH May 7, 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1913
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 19 Hours 66 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		11b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Dr. Robert Meszlenyi		14. MOTHER'S MAIDEN NAME Elizabeth Popeara	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 054 30 9818	
17. INFORMANT Dr. Ivan Lenart		Address 5480 Wis. Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brondogenic Carcinoma DUE TO 1621 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost - DUE TO - (c) -			INTERVAL BETWEEN ONSET AND DEATH 9 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4, 18, 66 , 19 66 , to 5, 7, 66 , 19 66 , that (I) (we) last saw the deceased alive on 5-7 , 19 66 , and that death occurred at 5:45 A.M. from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 5-7-66	
22c. PHYSICIAN'S NAME (Type) T. Ham II. D.		22d. ADDRESS 135 Center St. Vienna, Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 9, 1966	23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEM.	23d. LOCATION (City or Town) (County) (State) WASHINGTON D.C.
24. FUNERAL DIRECTOR H. Don. De Vol 2222 Wisconsin Ave NW		25. REC'D BY REGISTRAR MAY 12 1966	
		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



07193

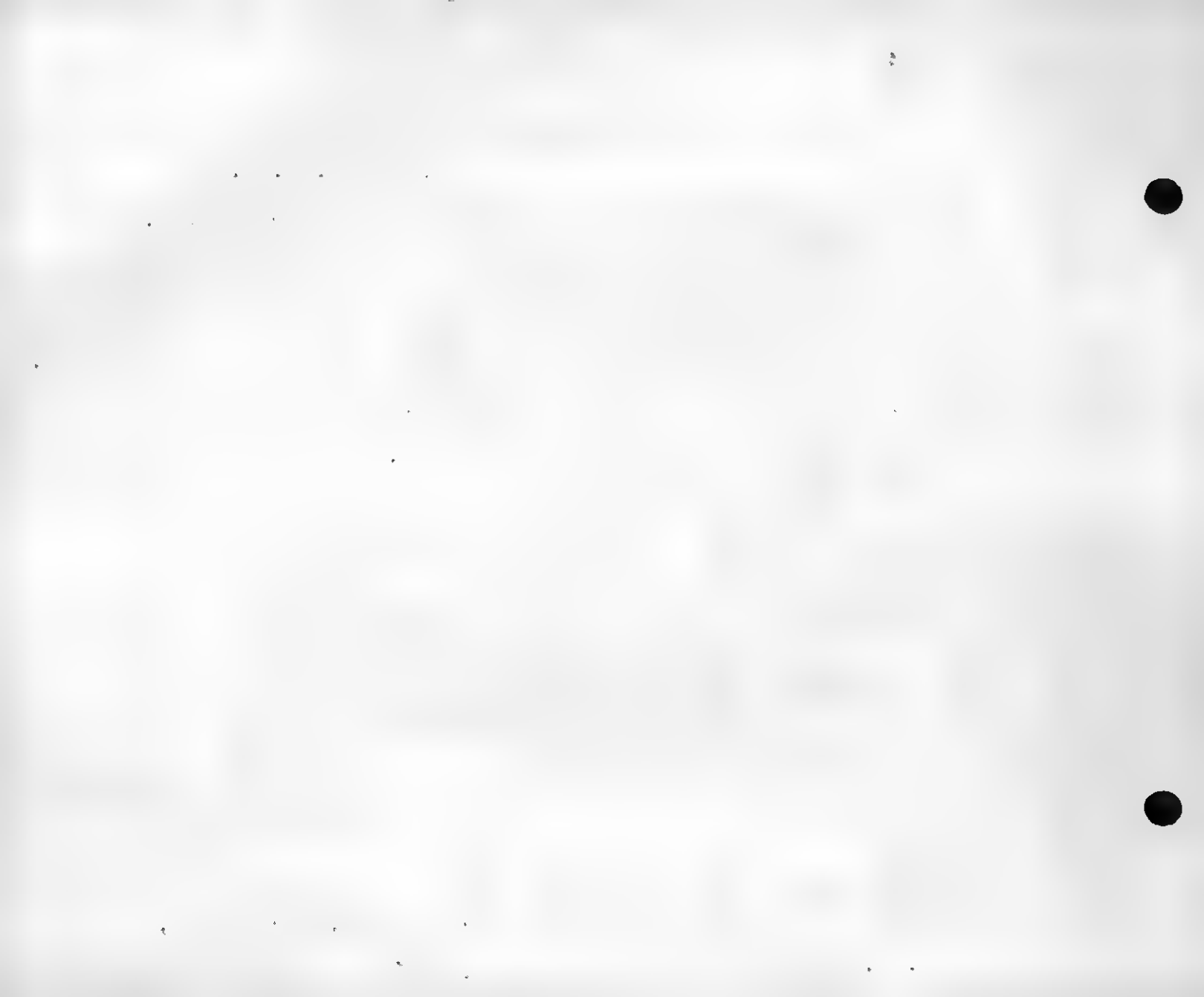
CERTIFICATE OF DEATH

07186

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Washington, D. C. b. COUNTY 11 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Sanitarium		d. STREET ADDRESS 3000 Tilden Street N. W.	
3. NAME OF DECEASED (Type or print) MASEL C. LEWIS		4. DATE OF DEATH MAY 29 1966	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/31/1890
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR 29 Months 19 Days 66 Hours 11 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Indiana	
11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John B. Stonebraker		14. MOTHER'S MAIDEN NAME Ada A. Garrigus	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WW#1		16. SOCIAL SECURITY NO none	
17. INFORMANT Theodore C. Lewis-		Address same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 congestive heart failure DUE TO (b) coronary insufficiency DUE TO (c) arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) bed		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/15, 1966 to 5/28, 1966 , that (I) (we) last saw the deceased alive on 5/28, 1966 , and that death occurred at 12:40 A.M. from causes and on the date stated above.			
22a. SIGNATURE Hon. B. C. Hines		22b. DATE SIGNED 5/28/66	
22c. PHYSICIAN'S NAME (Type) L. B. B. C. Hines		22d. ADDRESS 8885 Conn. Ave. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/2/66	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR The. S. H. Hines Company		25a. REC'D BY REGISTRAR Washington, D.C.	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. DATE JUN 2 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

07187

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (rural)		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Marion Nethery LITTLE		4 DATE OF DEATH Month May Day 23 Year 19 66	
5 SEX M	6 COLOR OR RACE Cauc.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 5, 1899
9 AGE (In years lost birthday) 66 yrs.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy	10b KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) Mobile, Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Little		14. MOTHER'S MAIDEN NAME Indel Roberts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes 1922-1952		16 SOCIAL SECURITY NO 578-48-2894	
17. INFORMANT CDR James G. Little, USN 3182 Key Blvd./		Address Arlington, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work _____ of work _____	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from May 22 , 19 66 , to May 23 , 19 66 , that (a) (we) last saw the deceased alive on May 23 , 19 66 , and that death occurred at 830A M, from causes and on the date stated above.			
22a SIGNATURE <i>F. C. Johnson</i>		22b DATE SIGNED 23 May 1966	
22c. PHYSICIAN'S NAME (Type) F. C. Johnson, M. D.		22d ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/26/66	23c NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia	
24. FUNERAL DIRECTOR Ives Funeral Home ADDRESS 2847 Wilson Blvd. Arlington, Va.		25a REC'D BY REGISTRAR MAY 25 1966	25b. REGISTRAR'S SIGNATURE <i>J. Charles Jones</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07195

07188

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens</u>		d. STREET ADDRESS <u>25 Laner Court</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>L. Lockwood</u> Last		4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1888</u>
9. AGE (In years, last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR: Months <u>80</u> Days <u>80</u> Hours <u>80</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY Lockwood</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Washburn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Sydia Lockwood - same as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Generalized Atherosclerotic Cardiovasc. Dis.</u> DUE TO (c) <u>Diabetes Mellitus</u> 2 yrs. INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u> <u>3-4 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> 2 yrs.			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> 19 to <u>18 May</u> 19 <u>66</u> , that (II) (we) last saw the deceased alive on <u>18 May</u> 19 <u>66</u> , and that death occurred at <u>7:38 P.</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Sydia Lockwood</u>		22b. DATE SIGNED <u>18 May 66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>5-19-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>MAY 23 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

M									
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
C7189									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN IB 106 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 613 West Montgomery Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Detlef Deitemar Loss			4. DATE OF DEATH Month May Day 12 Year 1966						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 13 March 1942		9. AGE (in years last birthday) 24 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Typist			10b. KIND OF BUSINESS OR INDUSTRY Federal Government			11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edwin T. Loss					14. MOTHER'S MAIDEN NAME Elvira Kotcerke				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 213-40-5763		17. INFORMANT The Medical Record The Clinical Center, Bethesda, Md. 20014				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric Thrombosis 4344 DUE TO (b) Brain stem infarction DUE TO (c) Multiple emboli secondary to possible cardiac damage PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 8 hours 5 months 3 years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 26 , 19 66 , to May 12 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 12 , 19 66 , and that death occurred at 2:35 from the causes and on the date stated above.									
22a. SIGNATURE Phillip Yarnell, M.D.					22b. DATE SIGNED 12 May 1966			22c. PHYSICIAN'S NAME (Type) Phillip Yarnell, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5-14-66		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY					ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR MAY 17 1966		
							25b. REGISTRAR'S SIGNATURE Charles Judge		

Cleared - Med. Examiner [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 5 HOURS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hosp., Md.		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 10212 MERIDITH AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAULINE Middle LOUIE Last DEATH		4. DATE Month MAY Day 30 Year 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY HOCKMAN		14. MOTHER'S MAIDEN NAME ELIZA SAGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Hattie Hockman		Address Winchester, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE DUE TO SHOCK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) HEMORRHAGING PEPTIC ULCER DUE TO (c) 10 HRS		INTERVAL BETWEEN ONSET AND DEATH 30 min 2 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 1965 to 5-20-66 , that (I) (we) last saw the deceased alive on 5-20-1966 , and that death occurred at 6:39 PM , from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 5-21-66	
22c. PHYSICIAN'S NAME (Type) JOHN S. ROGERS		22d. ADDRESS 1919 [Address]	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-24-66	
23c. NAME OF CEMETERY OR CREMATORY Imb. Helbron		23d. LOCATION (City, town or county) (State) Winchester, Va.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE [Signature]		DATE MAY 26 1966	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

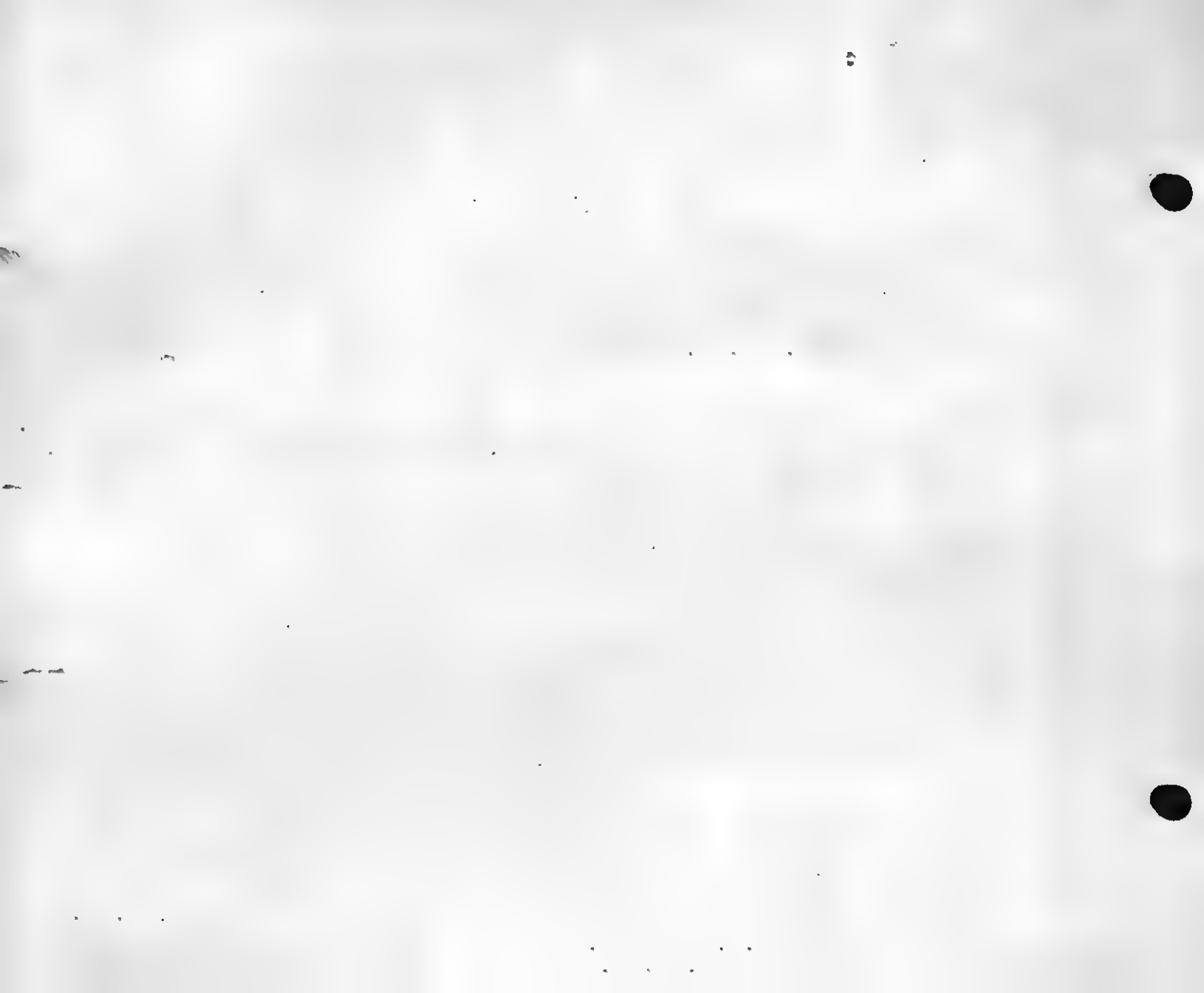
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of any event within 72 hours after death.

1 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Wash.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u>	
c. LENGTH OF STAY IN 1b <u>11 DAYS</u>		d. STREET ADDRESS <u>2703 Woodley Rd. NW 47-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>KENSINGTON GARDENS</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u></u> Last <u>LUCKETT</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11 1875</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Treasury Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas T LUCKETT</u>		14. MOTHER'S MAIDEN NAME <u>TERESA FENTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Marguerite Connors</u>		Address <u>5306 14th St NW Washington, DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.O.		22. DATE SIGNED <u>May 3, 1966</u>	
NAME (Type) <u>BELDEN R. REAP, M.D.</u>		22. DATE SIGNED <u>May 3, 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/6/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>MAY 5 1966</u>	
ADDRESS <u>Washington, D. C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



CERTIFICATE OF DEATH

07193

07192

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. LENGTH OF STAY IN I.B. <u>5 da 6 hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boysds</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eleanor</u> Middle <u>R</u> Last <u>Maughlin</u>				4. DATE OF DEATH Month <u>5</u> Day <u>18</u> Year <u>1966</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Can</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/7/82</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>11</u>	IF UNDER 24 HRS. Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Ray</u>				14. MOTHER'S M maiden name <u>Eleanor Gatch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>216-40-8507</u>		17. INFORMANT <u>Daughter</u>		Address <u>7004 Chesapeake</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>							INTERVA. BETWEEN ONSET AND DEATH <u>24 hr</u> <u>10 d</u> <u>2 wk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.H.F.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/14/66</u> to <u>5/18/66</u> , that (I) (we) last saw the deceased alive on <u>5/18/66</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>Stephen N. Jones</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN N. JONES</u>				22d. ADDRESS <u>809 Viers Mill Rd., Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-21-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Boysds Presby Ch. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Boysds, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>				25a. REC'D BY REGISTRAR <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1372

MARYLAND STATE DEPARTMENT OF HEALTH

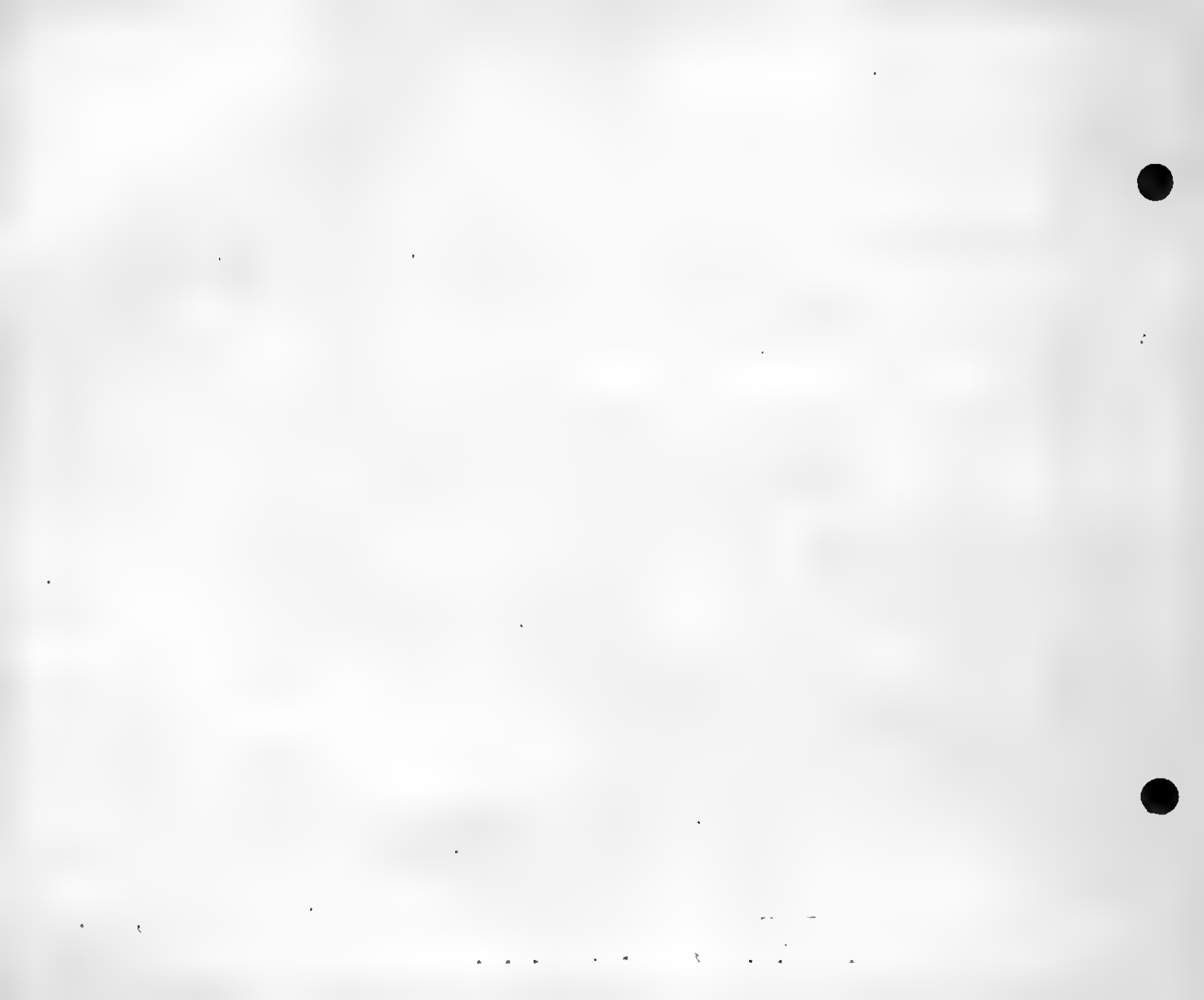
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C7200

07193

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>Washington D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in 1b <u>18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>4530 Dexter Street, N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Helen Marie Mayer</u>				4. DATE OF DEATH Month Day Year <u>May 22 1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-29-96</u>	
9. AGE (In years last birthday) <u>70 yrs.</u>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Gov't worker</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>	
13. FATHER'S NAME <u>Robert D. Mayer</u>				14. MOTHER'S MAIDEN NAME <u>Anna Wall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records - Washington San & Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO (b) <u>ACUTE CVA</u> DUE TO (c) <u>Severe generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4x of Ca breast (mastectomy) Severe psychotic depression</u>						INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>6 hrs prior</u> <u>several yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>65</u> to <u>5-22</u> , 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>5-21</u> , 19 <u>66</u> , and that death occurred at <u>2⁴⁵</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>R. H. Sandstrom</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/22/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RH. Sandstrom M.D.</u>				22d. ADDRESS <u>7701 Carroll Ave Takoma Park, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-25-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery Silver Spring, Md</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>Joseph Lawler's Sons, Inc. Wash. D.C.</u>				25a. REC'D BY REGISTRAR <u>MAY 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

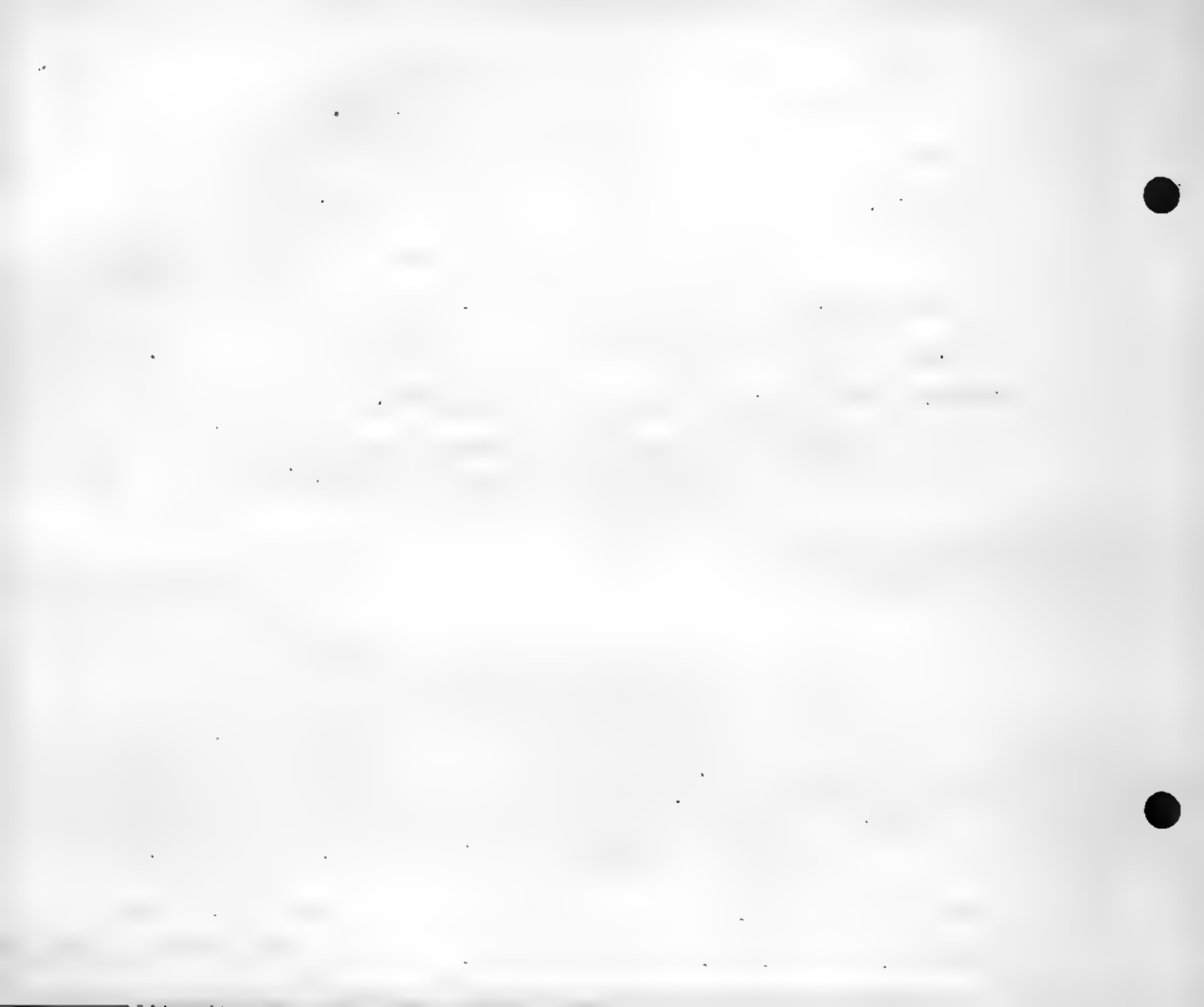


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>2611 Weisman Road</i>					d. STREET ADDRESS <i>2611 Weisman Road</i>				
3. NAME OF DECEASED (Type or print) First <i>Theresa</i> Middle <i>Katherine</i> Last <i>McDonnell</i>					4. DATE OF DEATH Month <i>5</i> Day <i>30</i> Year <i>1966</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 15, 1892</i>		9. AGE (In years last birthday) <i>73</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Ireland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Jeremiah Keane</i>					14. MOTHER'S MAIDEN NAME <i>Katherine (?)</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Gregory McDonnell</i> Address <i>2611 Weisman Rd. Wheaton, Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY FIBROSIS (HAMMAN RICH-SYND)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>X</i> DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>4/9</i> , 19 <i>65</i> , to <i>5/30</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5/29</i> , 19 <i>66</i> , and that death occurred at <i>12</i> AM, from the causes and on the date stated above.									
22a. SIGNATURE <i>David Goldenberg</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>5/30/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>DAVID GOLDENBERG</i>					22d. ADDRESS <i>16620 GEORGIA SILVER SPRING, MARYLAND</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>June 2, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Silver Spring, Maryland</i>	
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>					25a. REC'D BY REGISTRAR <i>JUN 2 1966</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>3-23-66 to 5-27-66</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9601 Loran Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Dale Roger McGraw</u> First Middle Last 4. DATE OF DEATH <u>May 27 1966</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>11-6-46</u> 9. AGE (In years last birthday) <u>19</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Maryland U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph F. McGraw</u> 14. MOTHER'S MAIDEN NAME <u>Ellen Dix</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO <u>YES</u> 17. INFORMANT <u>Chart-Washington Sanitarium T.P.</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic osteogenic Sarcoma</u> 1969 DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right Hemiplegia from Left Cerebral Embolus</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-29, 1958</u> , to <u>5-27, 1966</u> that (I) (we) last saw the deceased alive on <u>5-26, 1966</u> , and that death occurred at <u>2:40</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Russell B. Arnold</u> 22c. PHYSICIAN'S NAME (Type) <u>Russell B. Arnold, M.D.</u>		22b. DATE SIGNED <u>5/27/66</u> 22d. ADDRESS <u>1106 Spring St., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>31 May 66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln</u> 23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>		24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> 25a. REC'D BY REG. STRAR <u>JUN 2 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
27203					07196				
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY Barrett				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN ID 13 Days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Barrett				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland					d. STREET ADDRESS Box #126			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anthony George McGuire			First Middle Last		4. DATE OF DEATH May 4 1966		Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 July 1947		9. AGE (In years last birthday) 18 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. McGuire					14. MOTHER'S MAIDEN NAME Betty J. Hall				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. --		17. INFORMANT The Medical Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis, probably bacterial 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intra-abdominal malignancy undetermined DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1992			19. INTERVAL BETWEEN ONSET AND DEATH 4 Days		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 21 April 1966 , to 4 May 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4 May 1966 , and that death occurred at 9:10 , from the causes and on the date stated above.									
22a. SIGNATURE H. Thomas Foley, M.D.			M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4 May 1966		
22c. PHYSICIAN'S NAME (Type) H. Thomas Foley, MD.			22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 7 1966		23c. NAME OF CEMETERY OR CREMATORY Boone Memo. Park		23d. LOCATION (City, town or county) (State) Boone, W. Va.		
24. FUNERAL DIRECTOR Pearson Funeral Home			ADDRESS Falls Church, Va.		25a. REC'D BY REGISTRAR MAY 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07197

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived f institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>10 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Kate F. MEARS</u>		4 DATE OF DEATH <u>MAY 6 1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8/31/1867</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>---</u>	
13 FATHER'S NAME <u>John Waidlich</u>		14 MOTHER'S MAIDEN NAME <u>Maria Spangler</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>Unknown</u>	
17 INFORMANT <u>Miss Florence Mears-Same as Item #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>1047</u> DUE TO <u>Uremia -</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>Arterio-Sclerosis Generalized</u> DUE TO (b) <u>years</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fracture of Rt. Hip</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell at nursing home causing fracture of Rt Hip</u>	
20c TIME OF INJURY Month Day Year <u>4:20 pm 4/26 1966</u>		20d INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) <u>Nursing Home</u>
		20f (City or town) <u>Silver Spring Md</u>	(County) <u>Prince George</u> (State) <u>Md</u>
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>3/6/66</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b DATE THEREOF <u>5/6/1966</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d LOCATION (City or Town) (County) (State) <u>Prince George Co. Md.</u>	
24 FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
25a REC'D BY REGISTRAR <u>MAY 9 1966</u>		25b REGISTRAR'S SIGNATURE <u>John G. Ball</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only de ay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

A15 (4)
1/65

07198

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BOYDS		c. LENGTH OF STAY IN 1b 15		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BOYDS		d. STREET ADDRESS Maryland		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CLARA		First CLARA		Middle M.		Last MELVIN		4. DATE OF DEATH Month May		Day 11		Year 1966							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 27, 1915		9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 3 Days 14		IF UNDER 24 HRS. Hours 14 Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN E. COLE								14. MOTHER'S MAIDEN NAME MARY NICHOLS											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. unknown				17. INFORMANT Walter P. Melvin same item #2 -Husband											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, due 442X OUE TO Nephrosclerosis due Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) H.C.V.D. DUE TO Years (c) Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity INTERVAL BETWEEN ONSET AND DEATH Months Years Years																			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from MAY 2, 1966 to MAY 11, 1966 , that (I) (we) last saw the deceased alive on MAY 9, 1966 , and that death occurred at 10:00 A.M. from the causes and on the date stated above.																			
22a. SIGNATURE Jack Schumacher M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>																22b. DATE SIGNED 5-11-66			
22c. PHYSICIAN'S NAME (Type) Jack Schumacher																22d. ADDRESS 105 Russell Ave., Gaithersburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF 5/14/66				23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery				23d. LOCATION (City, town or county) (State) Barnesville, Maryland							
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home								ADDRESS 1331 Rockville Road, Rockville, Md.				25a. REC'D BY REGISTRAR MAY 13 1966				25b. REGISTRAR'S SIGNATURE g Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

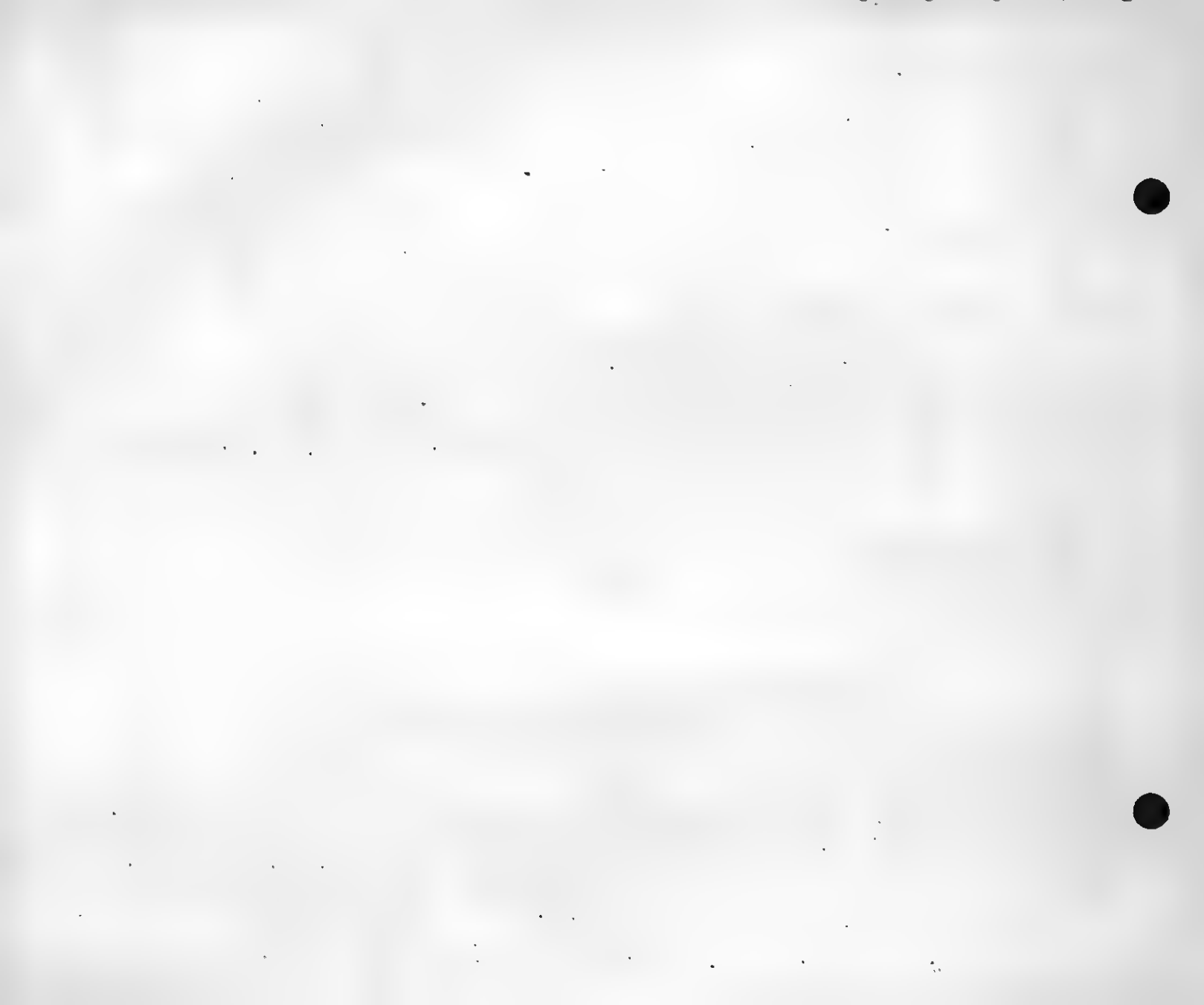
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN 1b Chevy Chase d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5209 Chamberlain ave		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 5209 Chamberlain ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALICE Middle S Last C. MERCHANT		4. DATE OF DEATH Month May Day 18th Year 1966	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11.24.1894
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR: Months 71 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vol worker		10b. KIND OF BUSINESS OR INDUSTRY Red Cross	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Amadeus Martin Coghlin		14. MOTHER'S MAIDEN NAME Clair Irvine Coghlin	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT James R. Murphy		Address Executor	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency DUE TO arterio-sclerotic Ht Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED while <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1943 to 5-18, 1966 , that (I) (we) last saw the deceased alive on 5-18, 1966 , and that death occurred at 12:30 M , from the causes and on the date stated above.			
22a. SIGNATURE Charles Judge		22b. DATE SIGNED 5-18-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5.19.66	
23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION (City, town or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR Lee Funeral Home		25a. REC'D BY REGISTRAR MAY 23 1966	
ADDRESS 300 4th st N E		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

12207
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
Item 11, Film G 376 5/20/66 J
CERTIFICATE OF DEATH
37200

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sevier Springs</u> c. LENGTH OF STAY IN 1b <u>years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>15450 Thompson Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sevier Springs</u> d. STREET ADDRESS <u>15450 Thompson Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nettie Morrison Melendy</u>		4. DATE OF DEATH Month Day Year <u>May 11 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 22, 1881</u>
9. AGE (In years, last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Francis Morrison</u>		14. MOTHER'S MAIDEN NAME <u>Mary Abbott Sharp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Daughters - 15450 Thompson Rd St.</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Generalized Arteriosclerosis</u> (c) <u>Generalized Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>MAY 11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>MAY 2</u> , 19 <u>66</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Smith, Jr.</u>		22b. DATE SIGNED <u>5/11/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Smith, Jr.</u>		22d. ADDRESS <u>Burtonsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 13, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville Md</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters, 254 Carroll N.W. 40c</u>		25. REC'D BY REGISTRAR <u>MAY 13 1966</u>	
25a. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



FOR STATE HEALTH DEPT.

07208

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07201

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Cape May</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Rt. #1 - Box 89</u>	
3 NAME OF DECEASED (Type or print) <u>Inger M. Milung</u>		4 DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-25-1886</u>
9 AGE (In years last birthday) <u>79</u>		10 UNDER 1 YEAR IF UNDER 24 HRS Months <u>7</u> Days <u>27</u> Hours <u></u> Min. <u></u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hair dresser Beauty operator</u>		11 BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12 CITIZENSHIP OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>Andrew Christensen</u>	
14 MOTHER'S MAIDEN NAME <u>Marie Hansen</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO. <u>UNKNOWN</u>		17 INFORMANT <u>Henry Walter Milung/Woodbine</u> Address <u>Rt. 1 Box 89</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia - Bronchial</u> (b) <u>Fracture of Right Hip</u> (c) <u>lost</u>			
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause <u>lost</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio Sclerosis - Sclerotized</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fall at home - 11 March 1966</u>	
20c TIME OF INJURY Month, Day, Year Hour <u>3</u> min <u>1</u> p.m. <u>1966</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u>Home</u>		20f (City or town) (County) (State) <u>Woodbine Cape May N.J.</u>	
21 I certify that I took charge of the removals described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Bethesda, Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>5/27/1966</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant</u>		23d LOCATION (City or Town) (County) (State) <u>Millville New Jersey</u>	
24 FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
25a REC'D BY REGISTRAR <u>MAY 27 1966</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Missouri b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kansas City	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 2305 Lawn Ave.,	
3. NAME OF DECEASED (Type or print) First Donald Middle Wayne Last MILLER		4. DATE OF DEATH Month May Day 2 Year 1966	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1945
9. AGE (in years last birthday) 20 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Army		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Booneville, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul Reed Miller		14. MOTHER'S MAIDEN NAME Frances Irene Allen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 492-46-3658	
17. INFORMANT Kansas City, Missouri		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme intracranial 8169 DUE TO and intraabdominal injuries with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary hemorrhage. DUE TO (c) Secondary hemorrhage.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) Deceased involved in head-on collision with another vehicle.	
20c. TIME OF INJURY Month, Day, Year 6 15 hour a.m. 4-30 p.m. 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Anne Arundel City, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Heap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. HEAP M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED May 2, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-7-1966	
23c. NAME OF CEMETERY OR CREMATORY Walnut Grove Cemetery		23d. LOCATION (City, town, or county) (State) Booneville, Missouri	
24. FUNERAL DIRECTOR W.W. Chambers Co.		25a. REC'D BY REGISTRAR MAY 9 1966	
1400 Chapin St., N. W. Washington, D. C.		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
C7210					07203				
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Prince George</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			c. LENGTH OF STAY IN 1b <i>7 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beltsville</i>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hosp. of Silver Spring</i>					d. STREET ADDRESS <i>4725 Naples Ave</i>				
3. NAME OF DECEASED (Type or print) First <i>Genevieve</i> Middle <i>Ruth</i> Last <i>Miller</i>					4. DATE OF DEATH Month <i>May</i> Day <i>14</i> Year <i>1966</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/26/08</i>		9. AGE (in years last birthday) <i>57</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Ernest K. Hubbard</i>					14. MOTHER'S MAIDEN NAME <i>Bessie Barton</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Robert H. Miller Same as #2 (Husband)</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis, primary site undetermined</i> DUE TO (b) <i>undetermined</i> DUE TO (c) <i>undetermined</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>May 1964</i> to <i>May 14, 1966</i> , that (I) (we) last saw the deceased alive on <i>5-14-1966</i> , and that death occurred at <i>10:00 AM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Jason Geiper</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5-14-66</i>		
22c. PHYSICIAN'S NAME (Type) <i>Jason Geiper, M.D.</i>					22d. ADDRESS <i>800 PERSHING DRIVE SILVER SPRING, MD.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/18/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Spring</i>		23d. LOCATION (City, town or county) (State) <i>Canonsburg, Pa.</i>			
24. FUNERAL DIRECTOR <i>Francis Gasch's Sons Hyattsville, Maryland</i>					25a. REC'D BY REGISTRAR <i>MAY 17 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
20M 1/65

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, if necessary, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>24 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>707 Downs Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>William</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/11/10</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>6</u> Hours <u>6</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Procurement manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Shore electronic center</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George W. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina Pape</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>096-03-7464</u>	
17. INFORMANT Address <u>707 Downs Drive, Silver Spring, Md.</u> <u>Mrs. Edith S. Miller</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> DUE TO (b) <u>Bronchogenic carcinoma with metastasis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>6 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 30, 1966</u> to <u>May 24, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 24, 1966</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Raymond Bradshaw</u>		22b. DATE SIGNED <u>5/24/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>		22d. ADDRESS <u>345 University Blvd., W. S. S., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>27 May 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>May 27 1966</u>	
ADDRESS <u>8434 Georgia Avenue, Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07212

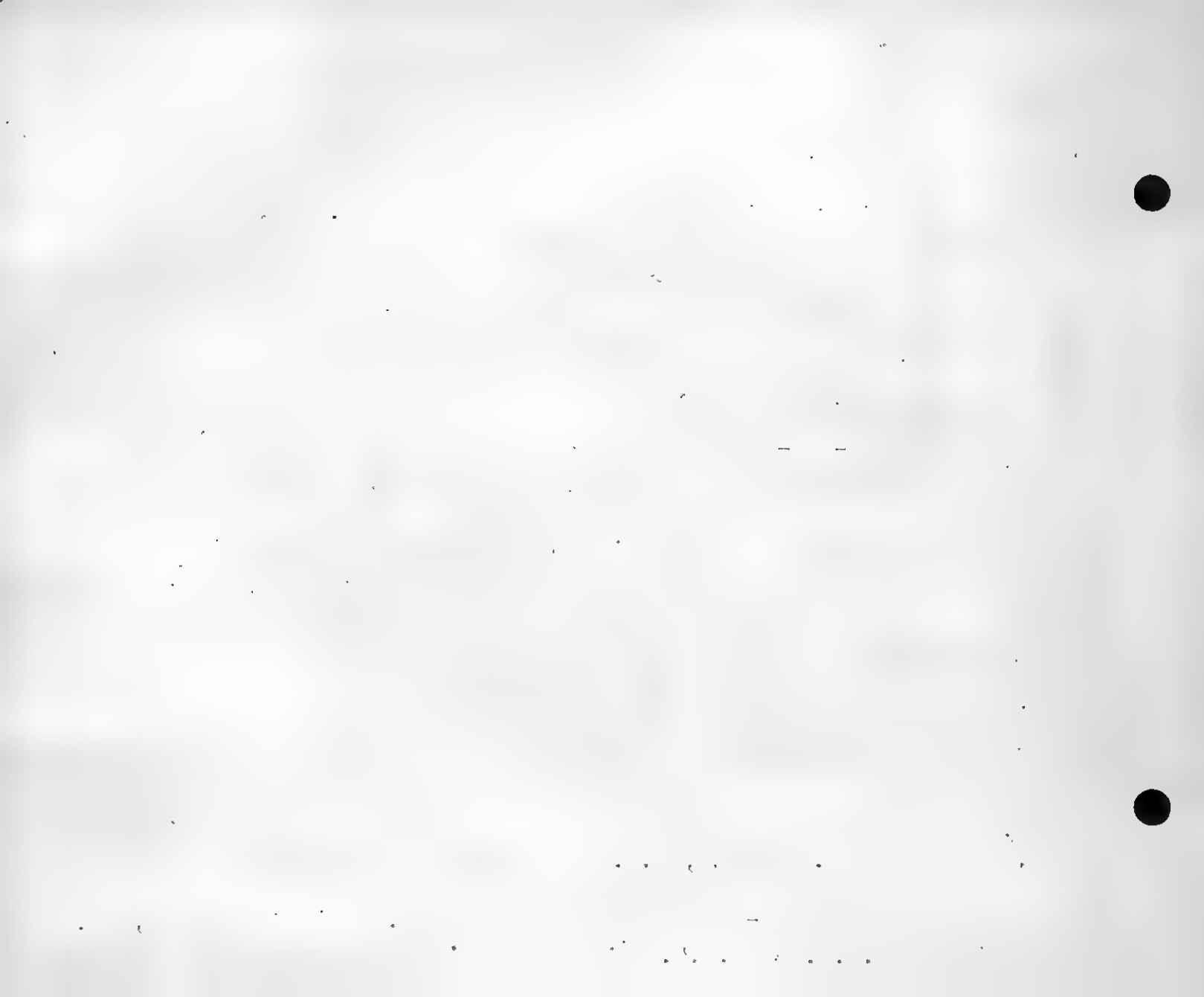
07205

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Virginia</i> b. COUNTY <i>Norfolk</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>1 hr 8 min</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>1233 Westover Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Parker</i> Last <i>Moffett</i>		4. DATE OF DEATH Month <i>May</i> Day <i>8</i> Year <i>1966</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-3-17</i>
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <i>Floor Finisher</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>E. A. Moffett</i>		14. MOTHER'S MAIDEN NAME <i>Brady</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Wm. P. Moffett</i>		Address <i>Same As #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gunshot wound, cerebrum, self-inflicted</i> 976X Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hour</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i>		22. DATE SIGNED <i>May 8, 1966</i>	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP, M.D.</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5/11/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rosewood Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Virginia Beach Virginia</i>
24. FUNERAL DIRECTOR <i>J. Wm. Lees Sons</i>		25a. REC'D BY REGISTRAR <i>MAY 12 1966</i>	
ADDRESS <i>300 4th St., NE Washington, DC</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

37213
Cleared with Medical Examiner - MA
BP

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 3 Film G378 6/27/66											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. LENGTH OF STAY IN 1b <u>Washington</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>											
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY											
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>ROBERT</u> Last <u>MONKS</u>											
4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1966</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/24/1907</u>		9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Oral Surgeon</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Raines Monks</u>						14. MOTHER'S MAIDEN NAME <u>Nora Lynch</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>- - - - -</u>					
17. INFORMANT <u>Mrs. Mary Monks</u>						Address <u>Washington, D. C.</u> <u>5715 48th St., N.W.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO (b) <u>Chronic congestive failure & cardiomyopathy</u> DUE TO (c) <u>Flecainide reorganization 2 Rheumatic</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1942</u> to <u>May 21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 20</u> 19 <u>66</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Thomas F. Kelihier</u>											
22b. DATE SIGNED <u>May 21 1966</u>											
22c. PHYSICIAN'S NAME (Type) <u>Thomas F. Kelihier, M.D.</u>											
22d. ADDRESS <u>3800 Reservoir Rd Wash DC</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5-24-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u>				23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md</u>	
24. FUNERAL DIRECTOR <u>Joseph Sawyer's Sons Inc. 5130 Wisc. Ave. N.W. Wash. D.C.</u>											
25a. REC'D BY REGISTRAR <u>MAY 25 1966</u>											
25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>											



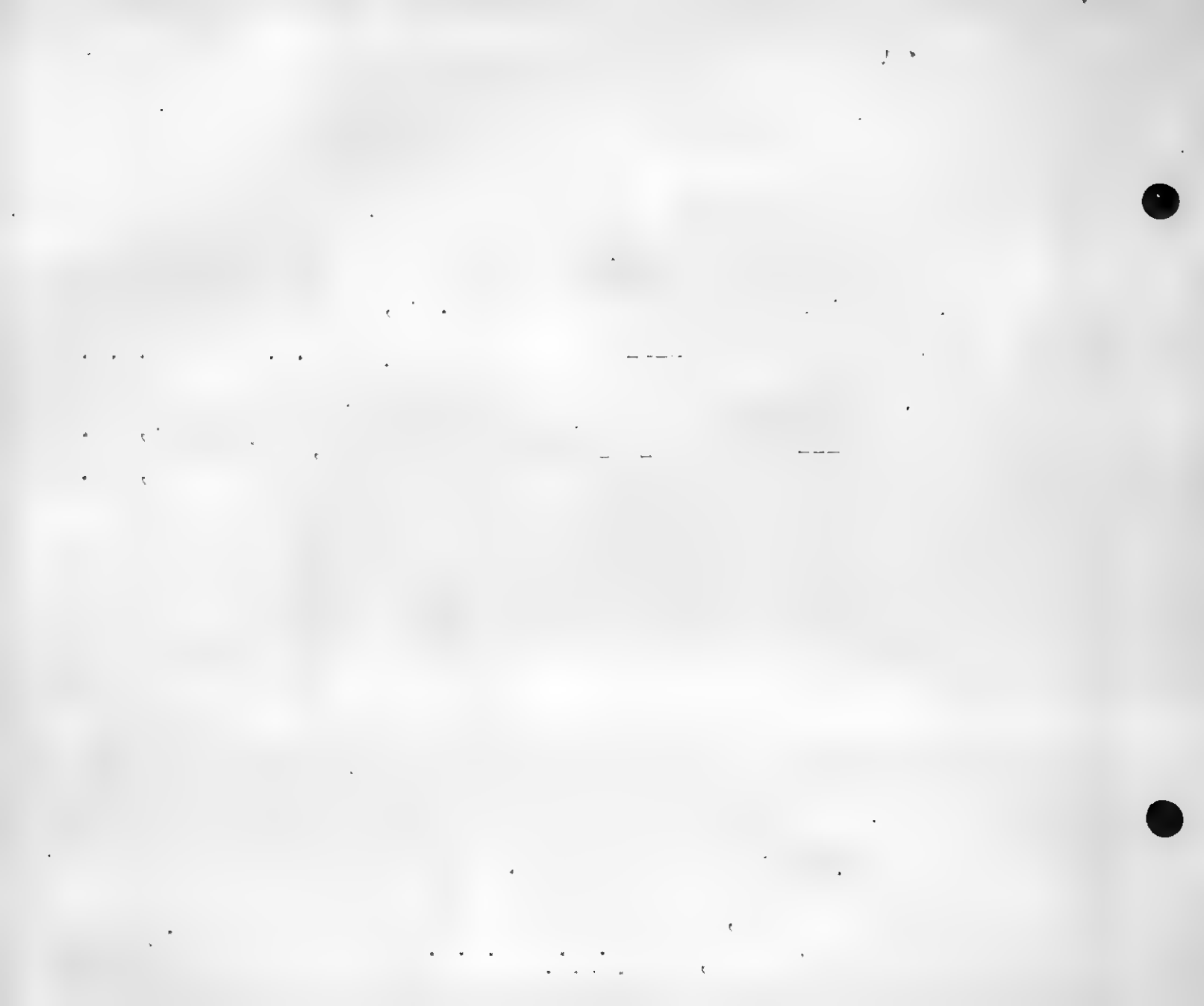
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
20M 1/65

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Clear with Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wheaton Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington d. STREET ADDRESS 4504 Saul Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First EDITH Middle DURYEE Last MORELL					4. DATE OF DEATH Month 5 Day 13 Year 1966									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 30, 1879		9. AGE (In years last birthday) 86 IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 13 Hours 19 Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (County & State, or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Redfield Duryee					14. MOTHER'S MAIDEN NAME Mary Frances Foote									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) ----					16. SOCIAL SECURITY NO. 220-46-4688					17. INFORMANT Edith Reynolds, 4504 Saul Road, Kensington, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Cerebrovascular Thrombosis DUE TO (c) Cerebral Arteriosclerosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephritis										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 1055 P.M. from the causes and on the date stated above.														
22a. SIGNATURE Nearby C. Scruggs MD					22b. DATE SIGNED 5/14/66		22c. PHYSICIAN'S NAME (Type) Nearby C. Scruggs MD							
22d. ADDRESS 5413 Cedar Lane Bethesda Md.					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF May 16, 1966		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory Suitland, Md.		23d. LOCATION (City, town or county) (State)								
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Wash. D.C.					25a. REC'D BY REGISTRAR MAY 18 1966									
					25b. REGISTRAR'S SIGNATURE Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be obtained by the hospital or attending physician, and completely filled out by the funeral director. OR: After this certificate has been signed by the attending physician, and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07208											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland				b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wheaton				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkland			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) University Nursing Home				d. STREET ADDRESS 117 Druid Pl.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Monroe Mothershead				4. DATE OF DEATH May 23 1966				5. AGE (In years last birthday) 92 yrs.			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 2/1873		9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Watchman				11. BIRTHPLACE (County & State, or foreign country) Va			
13. FATHER'S NAME Robert Motherhead				14. MOTHER'S MAIDEN NAME Emma Miller				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 577-09-2858				17. INFORMANT Melvin Mothershead Address Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Cardio - DUE TO Vascular Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) 15 years (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Washington		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from March 15, 1966 to May 23, 1966 that (I) (we) last saw the deceased alive on May 22, 1966 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.											
22a. SIGNATURE William Brainin				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 6124 Central Ave, Capitol Heights Md				22b. DATE SIGNED 5/26/66			
22c. PHYSICIAN'S NAME (Type) WM BRAININ											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/26/66		23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery				23d. LOCATION (City, town or county) Washington			
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home				ADDRESS Washington, D. C.				25. CLERK BY REGISTRAR May 26 1966			
				25b. REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>24 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>6 Nelson St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Anne Mullican</u> First Middle Last 4. DATE OF DEATH <u>May 30 1966</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Mar 3/9/28</u> 38 yrs. 9. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> 11. BIRTHPLACE (County & State, or foreign country) <u>45A</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Daniel Kallenburg</u> 14. MOTHER'S MAIDEN NAME <u>Georgia Linvale</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>218-20-0955</u> 17. INFORMANT <u>Milton R. Mullican same item # 2 (husband)</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CAROTID BRACHYEMIA</u> 7541 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SUBARACHNOID HEMORRHAGE + (INTERVENTRICULAR)</u> 24 hrs (c) <u>ARTERIOVENOUS MALFORMATION (RT. CEREBRAL PEDUNCLE)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>5-29</u> , 19 <u>66</u> , to <u>5-30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/30</u> , 19 <u>66</u> , and that death occurred at <u>9:00</u> PM, from the causes and on the date stated above. 22a. SIGNATURE <u>Francis C. Mayle</u> 22b. DATE SIGNED <u>5/31/66</u> 22c. PHYSICIAN'S NAME (Type) <u>Francis C. Mayle</u> 22d. ADDRESS <u>8218 Wisconsin Ave., Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>6/2/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Rockville Montg. Md.</u>		24. FUNERAL DIRECTOR <u>LYSON WALKER TH</u> ADDRESS <u>1331 ROCKVILLE RD. ROCKVILLE, MD.</u> 25a. REC'D BY REGISTRAR <u>JUN 3 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07217

07210

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 5 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. STREET ADDRESS 1017 South Quebec	
3 NAME OF DECEASED (Type or print) First Baby Middle Boy Last MURRAY		4. DATE OF DEATH Month May Day 17 Year 19 66	
5 SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1966
9 AGE (In years last birthday) yrs 5		10. IF UNDER 1 YEAR Months 5 Days 2 Hours 5 Min 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) Bethesda, Montgomery, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Johnnie R. Murray		14. MOTHER'S MAIDEN NAME Hiroko Matsuura	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Arlington Address Va. Johnnie Murray, 1017 South Quebec, Apt. 7/			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Prematurity and immaturity, Bilateral pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 17 , 19 66 , to May 17 , 19 66 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 17 , 19 66 , and that death occurred at 9:44 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Ronald F. Swanger</i>		22b. DATE SIGNED 18 May 1966	
22c. PHYSICIAN'S NAME (Type) Ronald F. Swanger, M. D.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REBURY (Specify)	23b. DATE THEREOF May 23, '66	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR <i>Murphy</i>		25a. REC'D BY REGISTRAR MAY 20 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1. 1. 1.

2. 2. 2.

3. 3. 3.

4. 4. 4.

5. 5. 5.

6. 6. 6.

7. 7. 7.

8. 8. 8.



CERTIFICATE OF DEATH

07218

07211

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN TB 16Hrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hosp.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Germantown Rural Rt. 1 d. STREET ADDRESS Maryland			
3. NAME OF DECEASED (Type or print) First Middle Last Roger Darby Nicholls				4. DATE OF DEATH Month Day Year May 8th 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 24th 1885	
9. AGE (in years last birthday) 81 Yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY III		11. BIRTHPLACE (County & State, or foreign country) Montg. Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Thomas Nicholls				14. MOTHER'S MAIDEN NAME Courtney Burdette			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 218-24-3140		17. INFORMANT Madeline T. Nicholls. Germantown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intestinal Hemorrhage due to Diverticulosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Adeno Carcinoma - upper left stem bronchus (c) Aspiration pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) A.I.D. & C.I.F.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 16, 1965 to May 8, 1966 , that (I) (we) last saw the deceased alive on MAY 7, 1966 , and that death occurred at 5 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Jack Schumacher M.D.				22b. DATE SIGNED 5-9-66			
22c. PHYSICIAN'S NAME (Type) Jack Schumacher.				22d. ADDRESS Gaithersburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-11-66		23c. NAME OF CEMETERY OR CREMATORY Park Lawn		23d. LOCATION (City, town or county) (State) Rockville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg, Md.				25a. REC'D BY REGISTRAR MAY 11 1966			
				25b. REGISTRAR'S SIGNATURE Charles J. J...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MONTGOMERY STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07219						07212					
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montg.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boyd</i>				c. LENGTH OF STAY IN 1b <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boyd</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Home</i>						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Evel</i> Middle <i>Thomas</i> Last <i>Nicholson</i>						4. DATE OF DEATH Month <i>May</i> Day <i>8</i> Year <i>1966</i>					
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5/20/1907</i>		9. AGE (In years last birthday) <i>58</i> yrs.		F UNDER 1 YEAR Months <i>5</i> Days <i>8</i> Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Insurance</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Business</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Montgomery</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John Thomas Nicholson</i>						14. MOTHER'S MAIDEN NAME <i>Jessie Ann Haysmude</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>212-12-5957</i>		17. INFORMANT Address <i>Edna Mary Nicholson, Boyd, Md</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute coronary</i> 41X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>following pneumonia</i> (c) <i>Chronic asthma</i> INTERVAL BETWEEN ONSET AND DEATH <i>few hours</i> <i>8 days</i> <i>years</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>April - 30 - 1966</i> , to <i>May 7 - 1966</i> , that (I) (we) last saw the deceased alive on <i>May 7 - 1966</i> , and that death occurred at <i>7:00 A.M.</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>William C. Miller, M.D.</i>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i>						22d. ADDRESS <i>7 Brooke Avenue, Greethsburg, Md</i>					
23a. BURIAL, CREMATION, REMOVALS (Specify) <i>Burial</i>				23b. DATE THEREOF <i>5/11/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Presbyterian</i>		23d. LOCATION (City, town or county) (State) <i>Boyd Md.</i>			
24. FUNERAL DIRECTOR <i>Constance C. Hilton Barnesville, Md</i>						ADDRESS		25a. REC'D BY REGISTRAR <i>MAI 11 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Jones</i>	

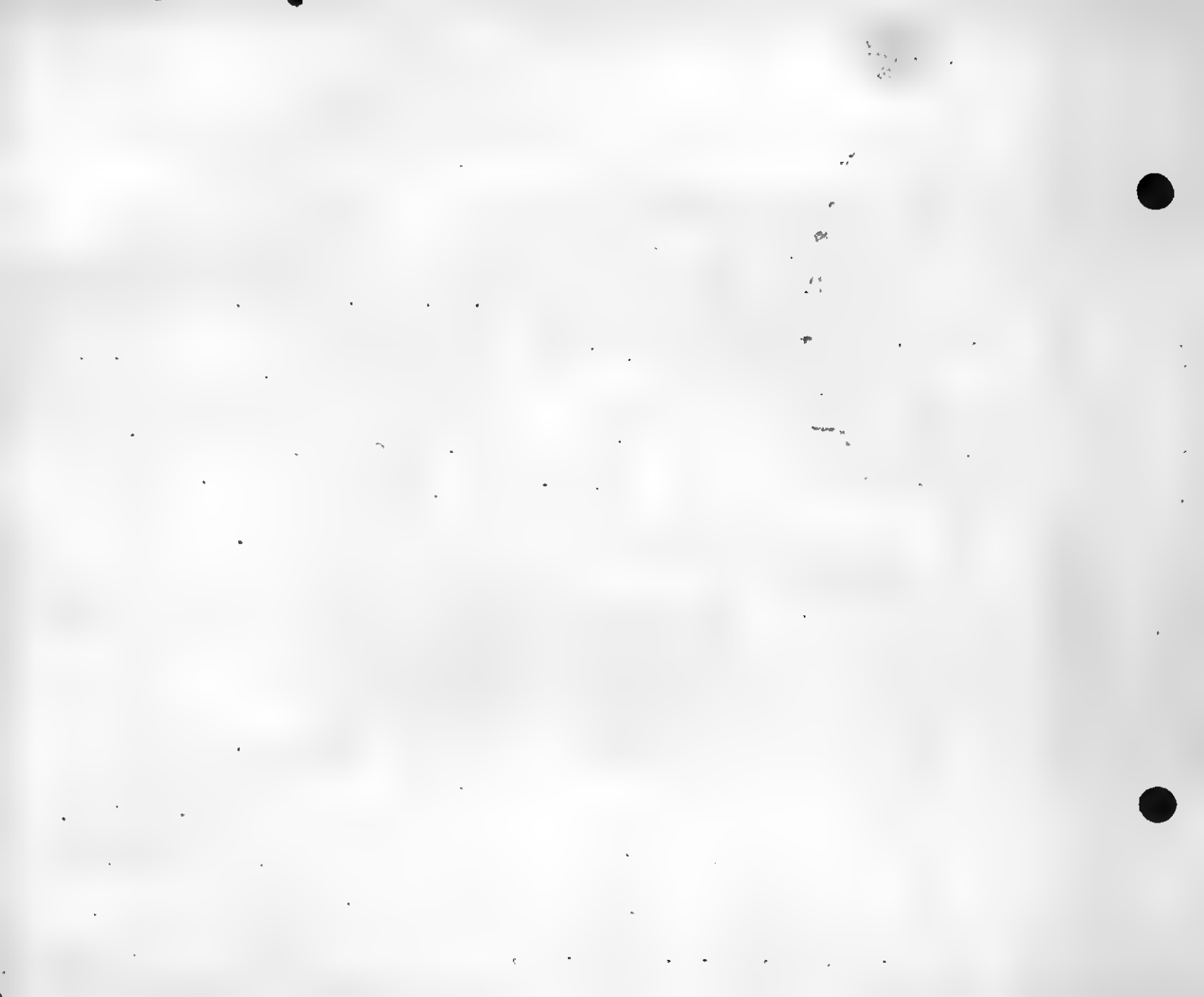
Released from Dr. Reap for signature
by Dr. Conean

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07220					37213				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wokoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution? Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mt. Ranier</u> d. STREET ADDRESS <u>3500 Trindel Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Henderson</u> Last <u>Noble</u>			4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1966</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 15, 1898</u>		9. AGE (In years last birthday) <u>67 yrs.</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry - Auto</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Clarence Noble</u>					14. MOTHER'S MAIDEN NAME <u>CAROLINE Dimmitt</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>578-07-0999</u>		17. INFORMANT <u>See C. Noble</u> Address <u>2500 Trindel Road Mt. Ranier, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>10 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>6/29, 1964</u> to <u>5/22, 1966</u> , that (I) (we) last saw the deceased alive on <u>5/13, 1966</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Norma D. Conean</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22b. DATE SIGNED <u>5/23/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Norma D. Conean</u>					22d. ADDRESS <u>3503 Perry St., Mt. Ranier, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>24 May 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George Co., Md.</u>			
24. FUNERAL DIRECTOR <u>Warner E. Porphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>					25a. REC'D BY REGISTRAR <u>MAY 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

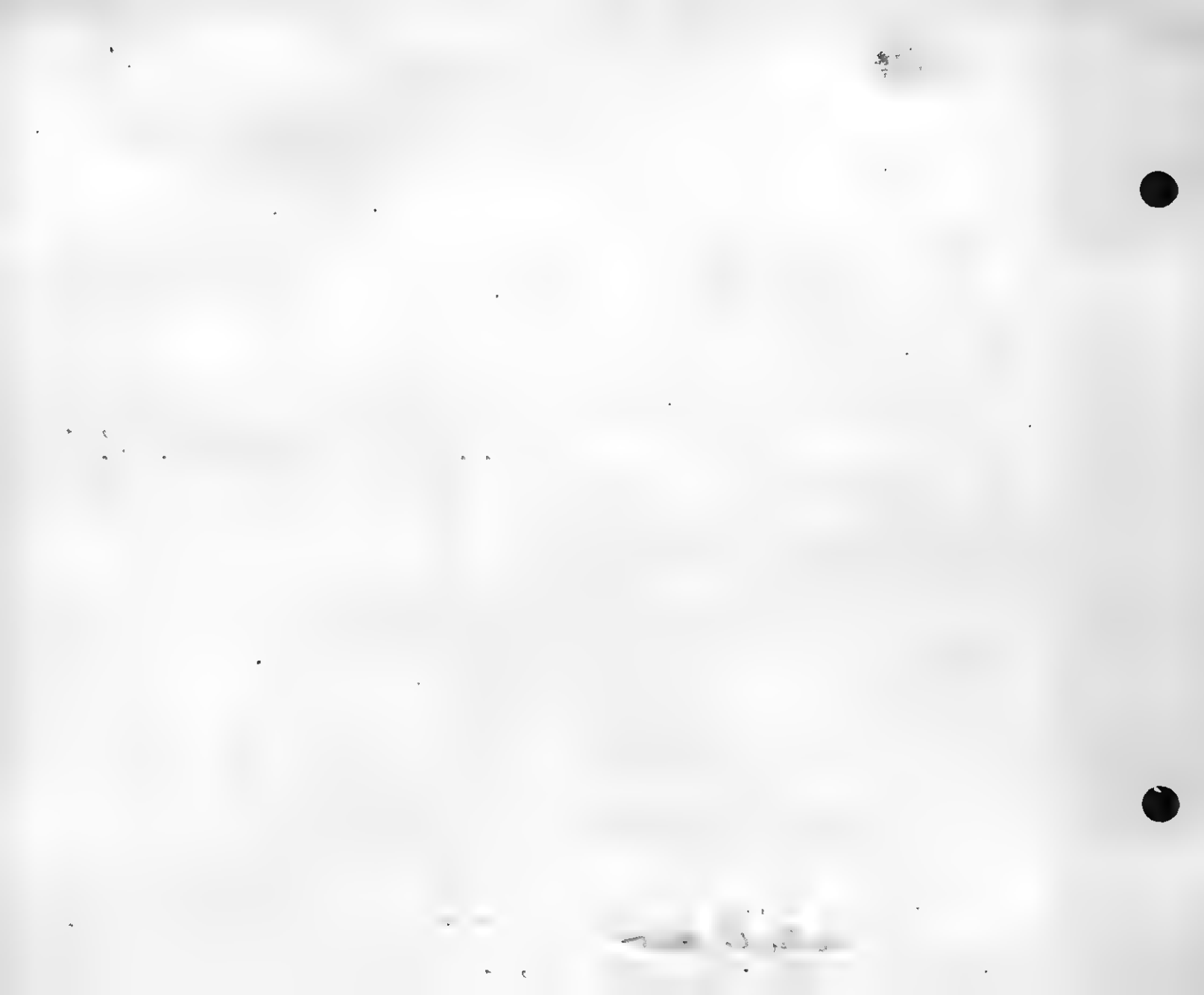
VR AISM 15
5M 1/65

07221

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>10401 Grosvenor Pl</u>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Carolyn</u> Last <u>Noel</u>				4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-11-1916</u>	9. AGE (In years last birthday) <u>49</u> yrs.	10. IF UNDER 1 YEAR Months <u>4</u> Days <u>9</u>	11. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Detroit, Mich</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George F. Puslow</u>				14. MOTHER'S MAIDEN NAME <u>Matilda George</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes give war or dates of service)</u>		17. INFORMANT Address <u>Bethesda, Md.</u> <u>Geo. R. Noel 5400 Pooks Hill Rd. Apt. 917</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Barbiturate Poisoning</u> DUE TO (b) <u>Overdose of Tolnal.</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u> <u>1/2 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Took over 80 capsules of Tolnal.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>10:30</u> a.m. <u>5/11</u> 19 <u>66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Bethesda Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Ball</u>				22. DATE SIGNED <u>5/11/66</u>			
EXAMINER'S NAME (Type) <u>John S. Ball</u>				Address (Street, city, town, or county) <u></u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/14/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Horst</u> <u>Rest Haven Funeral Chapel</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

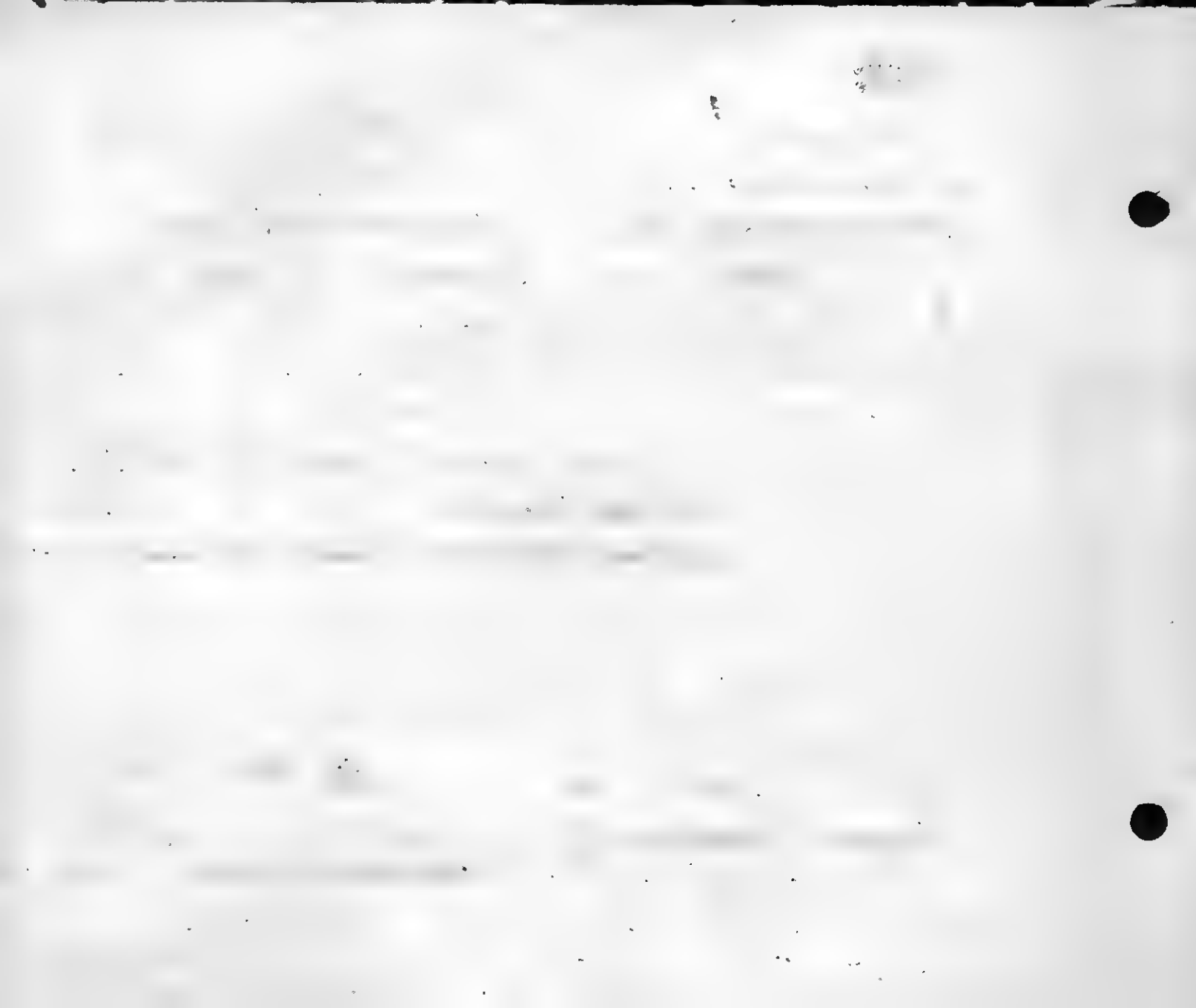
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07222

07215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>11 Months 5 Days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
				d. STREET ADDRESS <u>606 University Blvd, West</u>			
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>May</u> Last <u>O'Connor</u>				4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sep. 24, 1875</u>	
				9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner and operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gasoline & Center</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>William G. Wheatley</u>			
14. MOTHER'S MAIDEN NAME <u>Theresa Melson</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>			
16. SOCIAL SECURITY NO. <u>218-38-5676</u>				17. INFORMANT <u>Maurice W. O'Connor</u> Address <u>2305 E W Highway Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>10 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (i) (this hospital) attended the deceased from _____, 19 <u>56</u> , to <u>May 5</u> , 19 <u>66</u> , that (i) (we) last saw the deceased alive on <u>May 5</u> , 19 <u>66</u> , and that death occurred at <u>5:30</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Raymond Bradshaw, Jr.</u>				22b. DATE SIGNED <u>5/5/66</u>		22c. PHYSICIAN'S NAME (Type) <u>RAYMOND BRADSHAW, JR MD</u>	
22d. ADDRESS <u>345 University Blvd West Silver Spring, Md.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMAT., OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9 May 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
25c. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>				25d. DATE <u>MAY 9 1966</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07228

CERTIFICATE OF DEATH

07216

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c LENGTH OF STAY IN lb <u>13 days</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>			d STREET ADDRESS <u>3812 TOLVERNESS DR.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>NELSON</u> Middle <u>B.</u> Last <u>O'Neal</u>			4 DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1966</u>		
5 SEX <u>M</u>	6 CO. OR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-20-55</u>	9. AGE (In years last birthday) <u>11</u> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banking</u>		10b KIND OF BUSINESS OR INDUSTRY <u>-</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Martinsburg, West Va</u>	
13. FATHER'S NAME <u>Robert O'Neal</u>			14. MOTHER'S MAIDEN NAME <u>Cecelia Blonder</u>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Army</u>		16 SOCIAL SECURITY NO <u>597-22-1886</u>		17 INFORMANT <u>Evelyn P. O'Neal</u> Address <u>3812 Tolverness Dr. P. Ch. Ch., Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchiogenic Carcinoma & Metastases</u> 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema & Chronic Fibrosis</u> DUE TO (c) <u>of lungs</u>					INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 23, 1965</u> , to <u>May 16, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 15, 1966</u> , and that death occurred at <u>6:20 P.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>William F. Luckett</u>			22b. DATE SIGNED <u>5-16-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM F. LUCKETT</u>			22d ADDRESS <u>5000 PENN ROAD, N.W. - WASH. DC.</u>		
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5-19-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>	23d. LOCATION (City or Town) <u>Martinsburg</u>	(County)	(State) <u>W. Va.</u>
24. FUNERAL DIRECTOR <u>Joseph Gauder's Sons</u>			25a. REC'D BY REGISTRAR <u>May 23 1966</u>		
ADDRESS <u>5130 Wisc. Ave. N.W., Wash., D.C.</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

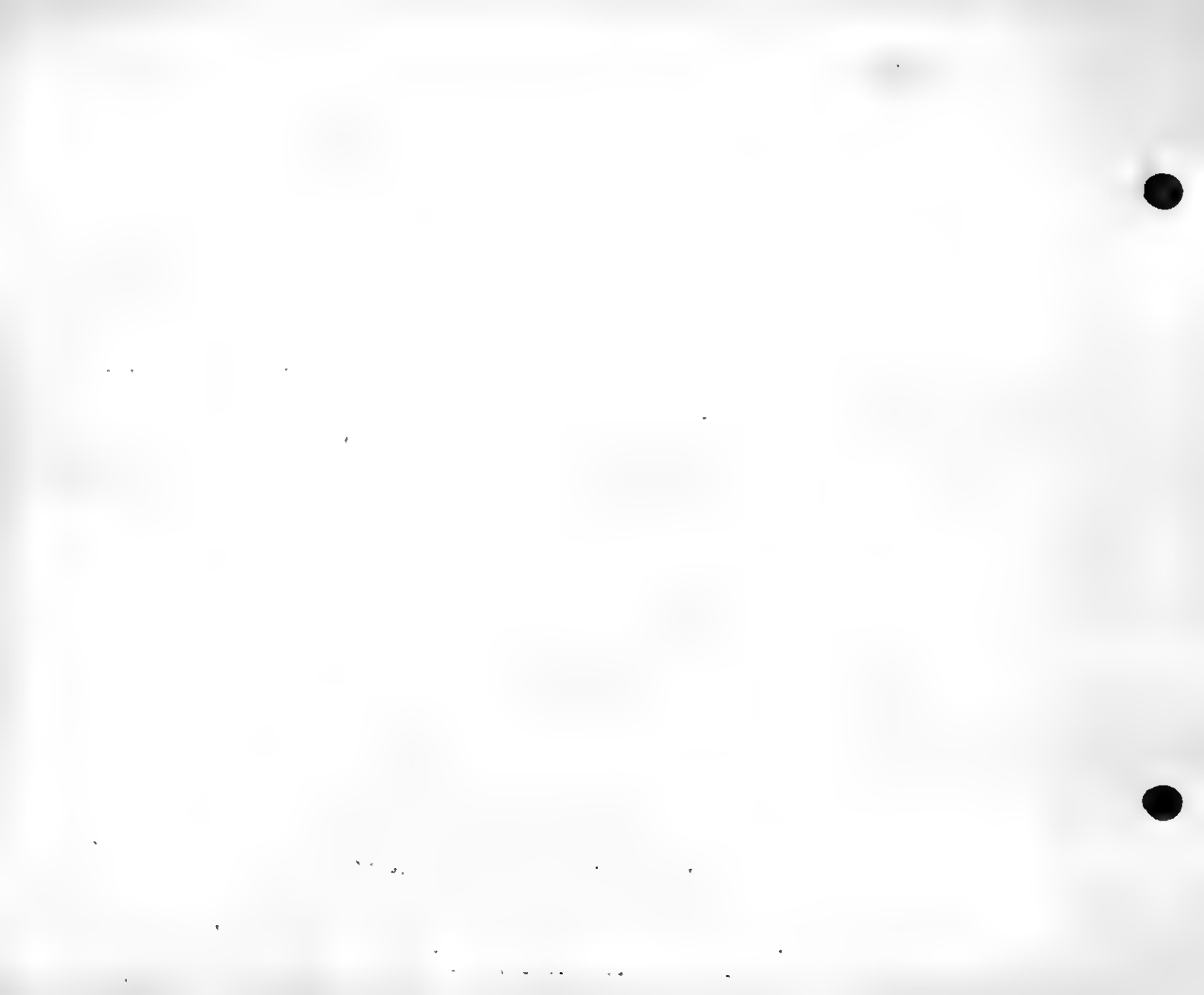
MEDICAL CERTIFICATION

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN lb <u>1 1/2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross Hospital</u>						d. STREET ADDRESS <u>304 Colesville Manor Drive</u>				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Snerry Lynn Orndorff</u>			4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>19 66</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>7/27/55</u>	
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. AGE (in years last birthday) <u>10</u> yrs			F UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXX Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Public school</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Loring Orndorff, Jr.</u>						14. MOTHER'S MAIDEN NAME <u>Lillie Anderson</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Father,</u> Address <u>Loring Orndorff, Jr., 304 Colesville Manor Dr., Sil. Spr., Md.</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY <u>124</u> IMMEDIATE CAUSE (a) <u>Multiple traumata including basilar skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>fracture sustained when struck by auto.</u> DUE TO (c) <u> </u>												
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased, a pedestrian, was struck by auto while walking along highway.</u>								
20c. TIME OF INJURY Month, Day, Year <u>2:15</u> <u>pm</u> <u>5/1</u> <u>19 66</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Silver Spring Montg. Md.</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Belden R. Reap, M.D.</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED <u>May 2, 1966</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Charles Judge</u>			Address (Street, City, Town, or County) <u> </u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 4, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Methodist Church</u>		23d. LOCATION (City or Town) (County) (State) <u>Moorefield, West Virginia</u>		25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>						ADDRESS <u>8434 Ga., Ave., S.S., Md.</u>		DATE <u>MAY 9 1966</u>				



07225

CERTIFICATE OF DEATH

07218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN TB <u>11 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>620 Anderson Ave</u>	
3. NAME OF DECEASED (Type or print) <u>First</u> <u>MILLARD</u> <u>Middle</u> <u>E</u> <u>Last</u> <u>PEAKE</u>		4. DATE OF DEATH <u>5-19</u> Month <u>5</u> Day <u>19</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/6/12</u>
9. AGE (in years last birthday) <u>54</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAXI DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DETHESDA CAB CO.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Millard P. P. P.</u>		14. MOTHER'S MAIDEN NAME <u>Margaret A. Tucker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Navy</u>		16. SOCIAL SECURITY NO. <u>578-18-4757</u>	
17. INFORMANT <u>Daughter Joan De Vries</u>		Address <u>Baithsburg</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fulminating Sepsis</u> DUE TO (b) <u>Probable gm - Organism</u> DUE TO (c) <u>Delirium Tremens</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Alcohol - Hemorrhage Gastritis & Hemorrhage</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Form 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>52</u> , to <u>5/19</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>5/19/1966</u> , and that death occurred at <u>1:15 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Stephen B. Jones</u>		22b. DATE SIGNED <u>5/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen Jones</u>		22d. ADDRESS <u>809 Veirs Mill Road, Rockville, Md.</u>	
23a. BURIAL OR CREMATION <u>BURIAL</u> (Specify)	23b. DATE THEREOF <u>5/21/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR <u>MAY 23 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or other event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

(M)

07226

CERTIFICATE OF DEATH

07220

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>1 1/2 hr.</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e STREET ADDRESS <u>1003 Thornwood Road</u>		f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>A. Williams</u> Middle <u>Postel</u> Last <u>Postel</u>				4 DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>1966</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan. 5 1908</u>	9 AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u> Hours <u></u> Min <u></u>		IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min <u></u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Analyst</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Albert Postel</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Williams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>217-44-0277</u>		17 INFORMANT <u>Mrs. Dorothy Postel</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infect. pneumonia, recent</u> DUE TO (b) <u>fat embolism, coronary disease</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , to <u>May 8</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>May 8</u> , 19 <u>66</u> , and that death occurred at <u>5 PM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>George Sharpe</u>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-May 66</u>		
22c. PHYSICIAN'S NAME (Type) <u>George Sharpe</u>			22d. ADDRESS <u>10511 Summit Ave. Kensington, Md.</u>				
23a BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>5/11/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>	
24 FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		25a RECD BY REGISTRAR <u>MAY 17 1966</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

07227

CERTIFICATE OF DEATH

07221

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) /OLNEY/ Gaithersburg, Maryland 15-1 d. STREET ADDRESS R.R. #2 BROOKE GROVE FOUNDATION e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CAROLINE WELLINGTON PRICE			4. DATE OF DEATH Month Day Year MAY 19 19 66				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-23-70		9. AGE (In years last birthday) 95 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME F. PRICE				
14. MOTHER'S MAIDEN NAME LAURA BRADY			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT MEDICAL RECORDS, Address OLNEY, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis - Gen'l. Feels. 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 1947 to May 18, 1966 , that (I) (we) last saw the deceased alive on May 18, 1966 , and that death occurred at 9:25 AM , from causes and on the date stated above.							
22a. SIGNATURE Jack Schumacher M.D.				22b. DATE SIGNED May 19, 1966			
22c. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M.D.				22d. ADDRESS RUSSELL AVE., GAITHERSBURG, MD.			
23a. BURIAL, CREMATION, RITUAL (Specify)		23b. DATE THEREOF May 21 1966		23c. NAME OF CEMETERY OR CREMATORY Mt. Taber			
23d. LOCATION (City or Town) Ethelton		(County) Montgomery		(State) Md.			
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonsville Md.		25a. REC'D BY REGISTRAR MAY 23 1966			
25b. REGISTRAR'S SIGNATURE Charles Judge							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN ID <u>3 mos. 26 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				15-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>						d. STREET ADDRESS <u>8434 Georgia Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Chiswell</u> Last <u>Pumphrey</u>			4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>1966</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 17, 1907</u>		9. AGE (In years last birthday) <u>59</u> yrs.		10. FUNERAL 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Funeral Director</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Funeral Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Dickerson, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Edward Lee Chiswell</u>						14. MOTHER'S MAIDEN NAME <u>Naomi North</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-16-0449</u>		17. INFORMANT <u>Mrs. James R. Miller</u> Address <u>Church Lane, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor</u> <u>237X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <u>3-4 wks</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <u>February 9, 1942</u> , to <u>May 10, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 10, 1966</u> , and that death occurred at <u>4:30 M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>W. B. Wardrop, M.D.</u>						22b. DATE SIGNED <u>May 11, 1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>W. B. Wardrop, M. D.</u>						22d. ADDRESS <u>808 Pershing Drive, Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>13 May 1966</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>						25a. REC'D BY REGISTRAR <u>MAY 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>g Charles Judge</u>			

